



**Tracking
Healthy People
2010**

This edition of *Tracking Healthy People 2010* supersedes the version contained in the January 2000 Conference Edition of *Healthy People 2010*. It includes revised information and the operational definitions for the Healthy People 2010 objectives. Updates to the operational definitions will be available periodically.

Tracking Healthy People 2010 is available at <http://www.cdc.gov/nchs/hphome.htm>. Data for the objectives will be updated in the DATA2010 database that also can be accessed at this Web site. For more information, call 301-458-4636.

Suggested citation: U.S. Department of Health and Human Services. *Tracking Healthy People 2010*. Washington, DC: U.S. Government Printing Office, November 2000.

M402D5446

HEALTHY PEOPLE 2010

Tracking Healthy People 2010

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U.S. Department of Health and Human Services
November 2000

Foreword

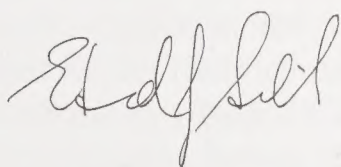
The ability to quantify and assess progress on health objectives is at the heart of the Healthy People initiative. Guided by two broadly defined goals—increasing years and quality of life and eliminating disparities in health among population groups—the core of Healthy People is a comprehensive set of objectives with specific targets that are numerically set, tracked, and evaluated.

Tracking Healthy People 2010 is a unique document and represents an important contribution to the Healthy People process. It is a comprehensive, authoritative guidebook on the statistics used for Healthy People—in effect the analytic framework for the program. Never before has the broad Healthy People community had this type of resource. This guidebook will assist in ensuring greater accuracy and comparability in the data produced for, and used by, Healthy People 2010 programs at the local, State, and national levels.

The earlier Healthy People initiatives built a legacy of considerable statistical and data management expertise and served as a catalyst for developing and promoting data resources at the national, State, and local levels. However, those earlier efforts lacked the important “data manual” at the start of the process to guide data collection and analysis. As Healthy People 2010 is launched, the data manual is ready. We have developed it to be useful to those who have highly varied experience. It will enable new members to join the coalition and immediately begin to produce and use the data, obtaining the necessary background information in an efficient and effective manner.

Healthy People has helped to set the health data agenda for the Nation. When Healthy People 2000 began, there were almost 100 objectives without baseline data. At the end of the decade just a few remained without data. Similarly, Healthy People 2010 has identified 139 developmental objectives, which are currently without national baseline data. These objectives are so important they have been identified as priorities for data collection. They are included in Healthy People 2010, illustrating the dynamic nature of the data process and the ongoing effort to provide data support for Healthy People.

Healthy People 2010 is a significant advance in the efforts to prevent disease and promote good health in America. Its statistical companion, *Tracking Healthy People 2010*, will greatly enhance our ability to monitor progress in achieving the Healthy People 2010 objectives.



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Director, National Center for Health Statistics

Acknowledgments

Tracking Healthy People 2010 is part of the Healthy People 2010 initiative that is coordinated by the U.S. Department of Health and Human Services. Overall responsibility for planning and developing the content of the volume rested with the Division of Health Promotion Statistics (DHPS), Office of Analysis, Epidemiology, and Health Statistics (OAEHP), National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention, under the direction of Diane K. Wagener and Richard J. Klein. Substantive review comments were received from Jennifer H. Madans, Acting Director, OAEHP, and Associate Director for Science, National Center for Health Statistics, and Deborah R. Maiese, Senior Health Policy Advisor, Office of Disease Prevention and Health Promotion (ODPHP), Office of Public Health and Science. Production coordination responsibility was shared among the DHPS analysts: Colleen M. Ryan, Kathleen M. Turczyn, Jeanette Guyton-Krishnan, J. Fred Seitz, and Elizabeth W. Jackson. Substantial help with the production of this volume was also provided by Jennie A. Wald and David Fessler.

Part A, General Data Issues, was developed and coordinated by Richard J. Klein. Substantial contributions were made by several NCHS staff members, including Harry Rosenberg, Donna Pickett, Ken Keppel, Paul Placek, and Gerry Hendershot.

The DHPS analysts had primary responsibility for the content of Part B, Operational Definitions. This section could not have been completed without the critical technical and substantive support provided by members of the 28 Healthy People 2010 Work Groups, particularly the Work Group Coordinators, listed in Appendix A, and DHPS computer programming specialists Thomas C. Socey, Jean F. Williams, and Cheryl R. Willis. Substantive review was also provided by members of the Healthy People Steering Committee, listed in Appendix D, *Healthy People 2010*.

Although Kathleen Turczyn had general responsibility for Part C, Major Data Sources for Healthy People 2010, the content was mainly provided by the persons responsible for the data systems that were described. These persons included David Nelson and Craig Leutzinger for the Behavioral Risk Factor Surveillance System; Alanna Moshfegh for the Continuing Survey of Food Intake by Individuals; Gary Edgar, Eva Seiler, and Gena Hill for the HIV/AIDS Surveillance System; Kate Rickard for the Medical Expenditure Panel Survey; Andrea Kopstein and Arthur Hughes for the Monitoring the Future Study; Cathy Burt for the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey; Michael Rand for the National Crime Victimization Survey; Cliff Johnson and Susan Schober for the National Health and Nutrition Examination Survey; Ann Hardy for the National Health Interview Survey; Robert Pokras for the National Hospital Discharge Survey; Joe Gfroerer and Beatrice Rouse for the National Household Survey on Drug Abuse; Nicole Smith for the National Notifiable Disease Surveillance System and National

Electronic Telecommunications System for Surveillance; Carol Brown and Marc Tomlinson for the National Profile of Local Health Departments; William Mosher for the National Survey of Family Growth; Harry Rosenberg and Jeffrey Maurer for the mortality component of the National Vital Statistics System; Stephanie Ventura for the natality component of the National Vital Statistics System; Wendy Lynch and Stephanie Pronk for the 1999 National Worksite Health Promotion Survey; Laura Kann for the School Health Policies and Programs Study and for the Youth Risk Behavior Surveillance System; Gabrielle Starr for the State Tobacco Activities Tracking and Evaluation System (STATE); Russ Roegner for the STD Case Reporting Surveillance System; and Lawrence Agodoa for the United States Renal Data System.

Help with the production of the appendices was provided by Jennie A. Wald, David Fessler, Cheryl R. Willis, Elizabeth W. Jackson, and Colleen M. Ryan, and Kathleen Turczyn under the direction of Richard J. Klein.

Social & Health Services, Ltd., (SHS) edited *Tracking Healthy People 2010* and prepared the document for publication, under the direction of senior managing editor, Nancy Klein. Other contributing staff members included Tiffanie Bilbrey, Carolyn Diaz, Lew Eigen, Eric Moore, Elaine Rahbar, Carli Richard, Steve Sonner, Emily Tinkler, and Arlene Weitzman.

Special thanks are due to Carter Blakey, ODPHP, and Mary Moien, SHS, for ensuring editorial consistency between *Healthy People 2010* and *Tracking Healthy People 2010*.

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Introduction

Healthy People 2010 builds on initiatives pursued over the past two decades. The latest of these, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*,¹ released in 1990, identified health improvement goals and objectives to be reached by the year 2000. The Healthy People 2010 initiative continues in this tradition as a catalyst to improve health for all Americans during the first decade of the 21st century. Many of the objectives that were in Healthy People 2000 also appear in Healthy People 2010, though some have been modified or adapted to reflect improvements in methodology and changes in the focus of public health policy.

*Healthy People 2010*² presents 467 objectives to improve the health of Americans by the year 2010. Because these objectives are national, not solely Federal, the achievement of these objectives is dependent in part on the ability of health agencies at all levels of the government and on nongovernmental organizations to assess objective progress. Systematically collecting, analyzing, interpreting, disseminating, and using health data is essential to understanding the health status of a population, to assessing progress, and to planning effective prevention programs. Therefore, data are the foundation of Healthy People objectives. Although the U.S. Department of Health and Human Services takes the lead role in national health data collection, it is only one partner within the larger structure necessary to collect information on the status and factors affecting the health of the population. The purpose of *Tracking Healthy People 2010* is to provide technical information so the many partners in this effort understand how the data are derived and the major statistical issues affecting the interpretation of the statistics.

The production of this document was made possible through collaboration with the Work Group Coordinators for each of the focus areas (see Appendix A).

Tracking Healthy People 2010 is organized into three sections.

- Part A: General Data Issues discusses issues that affect many objectives. This section includes important U.S. and international statistical practices that affect the definitions for the objectives and the ability to collect relevant information. One example is the recommendation to change the age-adjustment standard population weights for mortality and other data from various standards previously used to the year 2000 U.S. standard population weights. Appendix C presents a comparison of rates for the age-adjusted mortality objectives adjusted to the previously used 1940 standard and the 2000 standard.

- Part B: Operational Definitions provides definitions for each of the Healthy People 2010 objectives. The purpose of these definitions is to give the necessary technical information so the statistics can be reproduced for the national populations and comparable statistics can be calculated for other populations. If complete information for an objective definition is not available at the time of publication, the reader is directed to experts who can provide additional information.
- Data for the national Healthy People 2010 objectives come from 190 data sources. Of these, there are 23 data sources that each are used to track 5 or more objectives. These 23 sources are responsible for tracking more than three-fifths of the Healthy People 2010 objectives. Part C: Major Health Data Sources describes characteristics of the 23 major data systems used for Healthy People 2010. These characteristics are important considerations for others trying to develop similar data sources or trying to use the data sources for other purposes, such as the calculation of statistics for other select populations.

Appendices A through H provide information on the Healthy People 2010 Work Group Coordinators, abbreviations and acronyms used in *Healthy People 2010*, comparisons of age-adjusted death rates using the 1940 and 2000 standard population, ICD-9 and ICD-9-CM codes used in the objectives, crosswalks between the Healthy People 2000 and Healthy People 2010 objectives, and a list of the Healthy People 2010 objectives that are Leading Health Indicators.³

References

1. U.S. Department of Health and Human Services (HHS). *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: HHS, Public Health Service, 1991.
2. HHS. *Healthy People 2010*. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office (GPO), November 2000.
3. HHS. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: GPO, November 2000.

Part A:

General Data Issues

1. Target Setting and Assessing Progress for Measurable Objectives

Target-Setting Methods

One of the three overarching goals for the Healthy People 2000 prevention initiative was to reduce health disparities among Americans.¹ The framework of Healthy People 2010 has taken this a step further by proposing to “eliminate health disparities” as one of the two primary goals for the next decade.

To support this goal of eliminating health disparities, a single national target that is applicable to all select populations has been set for each measurable, population-based objective. Three guiding principles were used in setting targets for the measurable, population-based objectives:

- For objectives that address health services and protection (for example, access to prenatal care, health insurance coverage, etc.) the targets have been set so that there is an improvement for all racial/ethnic segments of the population (that is, the targets are set “better than the best” racial/ethnic subgroup shown for the objective). Data points for at least two population groups under the race and ethnicity category are needed to use “better than the best” as the target-setting method.
- For objectives that can be influenced in the short term by policy decisions, lifestyle choices, and behaviors (for example, physical activity, diet, smoking, suicide, alcohol-related motor vehicle deaths, etc.), the target setting method is also “better than the best” group.
- For objectives that are unlikely to achieve an equal health outcome in the next decade, regardless of the level of investment (for example, occupational exposure and resultant lung cancer), the target represents an improvement for a substantial proportion of the population and is regarded as a minimum acceptable level. Implicit in setting targets for these objectives is the recognition that population groups with baseline rates already better than the identified target should continue to improve.

Beyond this general guidance, the exact target levels were determined by the lead agency workgroups that developed the objectives. The workgroups used various methods for arriving at the target levels, including retention of the year 2000 target, computation of a statistical regression using current rates to project a target, knowledge of the programs currently in place and expected change, and expert judgment.

The following target-setting methods have been used:

- Better than the best.
- ___ percent improvement.
- “Total coverage” or “Total elimination” (for targets like 100 percent, 0 percent, all States, etc.).
- Consistent with _____ (another national program, for example, national education goals).
- Retain year 2000 target (the Healthy People 2000 target has been retained).

The specific method for developing the target is described under each objective in *Healthy People 2010*.²

Assessing Progress

Most objectives are tracked by a single measure. For these objectives, progress will be assessed by the change from the baseline measure toward the target. Some objectives seek to increase positive behaviors or outcomes while others are stated in terms of decreasing negative behaviors or outcomes.

A number of objectives contain multiple measures. Progress will be assessed separately for each measure. For these objectives, therefore, the progress may be mixed if some measures are progressing toward the target and others are regressing. Whenever possible, assessment of progress should consider the standard errors associated with the data (see section 9. Variability of Estimates).

For some objectives, precise measures that match the objective are not available. In these cases, similar proxy measures may be used to track progress. The tracking data and methods for assessing progress will be reviewed during the midcourse review in 2005, and a determination will be made at that time whether any changes will be made.

References

1. U.S. Department of Health and Human Services (HHS). *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: HHS, Public Health Service (PHS), 1991.
2. HHS. *Healthy People 2010*. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

2. Developmental Objectives

Developmental objectives are those that currently do not have national baseline data (see Reader's Guide section in *Healthy People 2010*¹) and, therefore, currently have no operational definitions. Some objectives that contain several measures may have parts that are developmental. Developmental objectives indicate areas that need to be placed on the national agenda for data collection. They address subjects of sufficient national importance that investments should be made over the next decade to measure their change.

A potential data source has been identified for all developmental objectives or subobjective measures. These sources, along with other information, will be discussed in the operational definitions under "Comments." As data are developed and become available for these objectives, operational definitions will be disseminated on the Internet and/or in Healthy People publications. No targets have been set for developmental objectives; targets will be proposed at the midcourse review for those developmental objectives that have baseline data.

Reference

1. HHS. *Healthy People 2010*. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

3. Population Estimates

Healthy People 2010 uses population estimates from the U.S. Census Bureau to calculate morbidity and mortality rates for many of the objectives. Every 10 years, the Census Bureau conducts a full census of the resident population of the United States, Puerto Rico, and U.S. territories and collects data on gender, race, age, and marital status; the estimates produced represent the U.S. population as of April 1 of the census year. More detailed data on education, housing, occupation, income, and other information are also collected from a representative sample of the population (about 17 percent of the total population).¹

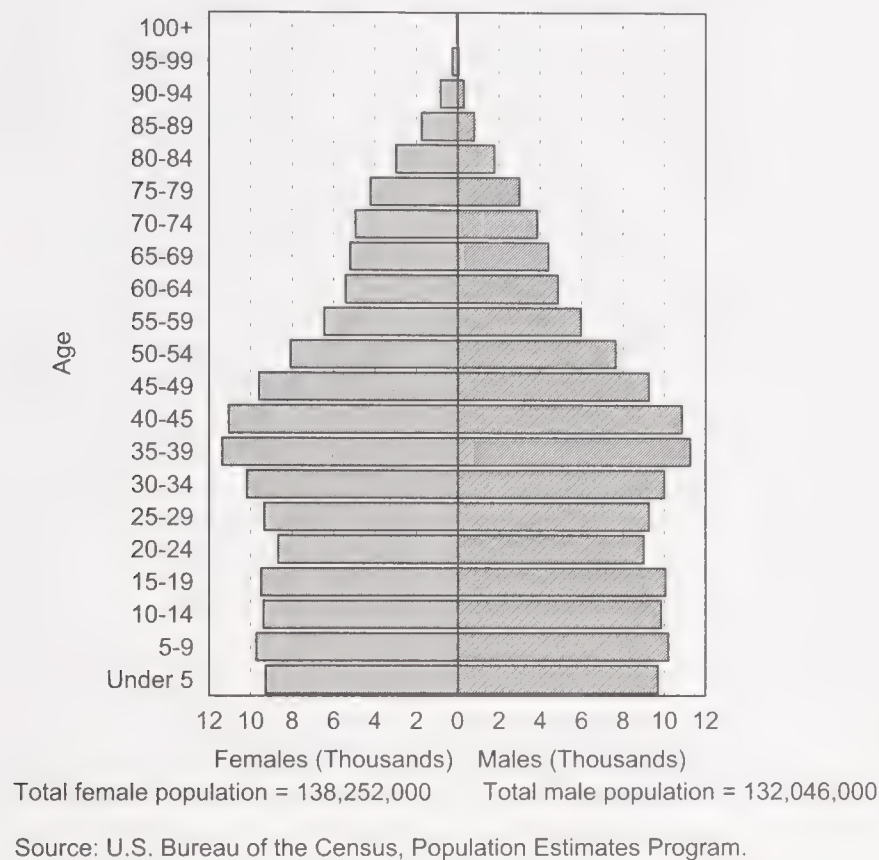
The increasing diversity of the population has necessitated modification of the way race data are collected. In both the 1980 and 1990 censuses, a substantial number of persons did not specify a racial group that could be classified as any of the categories on the census form (white, black, American Indian, Eskimo, Aleut, Asian, or Pacific Islander).² In 1980, the number of persons of “other” race was nearly 7 million; in 1990 it was almost 10 million. In both censuses, the majority of these persons were of Hispanic origin (based on response to a separate question on the form), and many wrote in their Hispanic origin, or Hispanic origin type (for example, Mexican, Puerto Rican) as their race.

The Census Bureau presents population data by race in two different ways. In decennial census publications, persons of unspecified race are maintained in the single category of “other.” For the purpose of providing comparable denominator data to other Federal and non-Federal data users, in both 1980 and 1990, the Census Bureau produced another set of population estimates for census years; in these population estimates, persons of unspecified race were allocated to one of the four tabulated racial groups (white, black, American Indian or Alaska Native, Asian or Pacific Islander), based on their response to the Hispanic question. These four race categories conform with Office of Management and Budget (OMB) Directive 15³ and are more consistent with the race categories used in most major data systems, including vital statistics.⁴ The postcensal and intercensal population estimates described below are based on these “OMB-consistent” populations.

Postcensal Population Estimates

National population estimates for the years after the decennial census (postcensal estimates) are calculated using the decennial census as the base population and adjusting those counts using the following measures of population change: births and deaths (provided by the National Center for Health Statistics), immigration data (provided by the U.S. Immigration and Naturalization Service), data on the movement of Armed Forces personnel (from the U.S. Department of Defense [DoD]), movement between Puerto Rico and the U.S. mainland (from Puerto Rico Planning Board), and movement of Federal employees abroad (from the Office of Personnel Management and DoD). These estimates reflect the U.S. population as of July 1 of each year (see figure 1). Postcensal estimates for State and county

Figure 1. Resident population by age and gender, United States, 1998.



populations are also calculated using these data, as well as data from the Internal Revenue Service and State departments of education. Postcensal estimates become less accurate as the date of the estimates moves farther from the date of the census.⁵

Intercensal Estimates

After the decennial population census, intercensal estimates for the preceding decade are calculated to replace postcensal estimates. These estimates reflect the population as of July 1. Intercensal estimates are more accurate than postcensal estimates because they incorporate data from the enumerations at the beginning and end of the decade. The intercensal estimates for the 1980s were used to revise some of the baselines for mortality objectives in Healthy People 2000; these were published in the *Healthy People 2000 Midcourse Review and 1995 Revisions*.⁶ The method that will be used to calculate intercensal estimates for the decade between 1990 and 2000 has not been developed because of the change in race and ethnicity data that will be collected in the year 2000 census (see section 4: Population Template). However, when the intercensal estimates for the decade become available, they will be used to recalculate some of the morbidity and mortality data for Healthy People 2010 baselines and tracking data for data years prior to the year 2000.

Population Undercounts

Some subgroups of the population (including some racial, ethnic, and age groups) are less likely than other groups to be completely enumerated in the decennial census. The undercounts of these groups lower the denominators and result in higher morbidity and mortality rates for these populations.^{7,8} The Census Bureau makes estimates of net census undercount for the total, white, and black or African American populations by age. These estimates are then used to weight the populations used by most of the national health surveys, including National Health Interview Survey (NHIS), National Health and Nutrition Examination Survey (NHANES), the National Survey of Family Growth, and the National Health Care Surveys. The National Vital Statistics System (NVSS) (mortality and natality) use population denominators that are not adjusted for net census undercount.

Target Populations

Several types of target populations are used for Healthy People 2010 objectives:

Resident Population

The resident population includes all persons whose usual place of residence is in one of the 50 States or the District of Columbia, including Armed Forces personnel stationed in the United States. The resident population is usually the denominator when calculating birth and death rates from the NVSS and incidence of disease rates from a number of data systems. The resident population is also the denominator for selected population-based rates that use numerator data from the National Nursing Home Survey.

Civilian Population

The civilian population is the resident population, excluding members of the Armed Forces (although their family members are included). The civilian population is the denominator for other Healthy People 2010 data sources, such as the National Hospital Discharge Survey.

Civilian, Noninstitutionalized Population

The civilian, noninstitutionalized population is the civilian population not residing in institutions (for example, correctional facilities, psychiatric hospitals, and nursing homes). This population is the denominator for rates from Healthy People data sources such as the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Care Survey. This population is also used in the weighting procedure to produce national estimates from health surveys such as NHIS, NHANES, and the National Household Survey on Drug Abuse.

Details on the specific populations targeted for each major Healthy People 2010 data system can be found in the data source tables included in Part C: Major Data Sources. The objective operational definitions shown in Part B indicate the population covered by each objective, if applicable.

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3. Office of Management and Budget (OMB). Directive No. 15. Race and ethnic standards for Federal statistics and administrative reporting. *Statistical Policy Handbook*. Washington, DC: OMB, 1978.
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7. NCHS. *Vital Statistics of the United States, 1992, Vol. II Mortality, Part A*. Technical appendix. Hyattsville, MD: HHS, PHS, 1996.
8. Rosenberg, H.M.; Maurer, J.D.; Sorlie, P.D.; et al. Quality of death rates by race and Hispanic origin: A summary of current research, 1999. NCHS. *Vital and Health Statistics* 2(128), 1999.

4. Population Template

Minimum Template

During the review of the September 1998 *Healthy People 2010 Draft for Public Comment*,¹ the need for greater consistency in tracking population groups became apparent. To address this issue, a minimum template for all Healthy People 2010 population-based objectives was adopted. Population-based objectives may show more detailed and additional breakouts if appropriate.

This minimum select population template applies to most currently measurable population-based objectives and will be applied to developmental population-based objectives (see section 2. Developmental Objectives) when data become available. The template does not apply to non-population-based objectives such as those that measure schools, worksites, or States. Because of problems in interpreting risk, the template is also not shown for population-based measurable objectives that are tracked using counts of events rather than rates or percents.

The minimum template for all population-based objectives is:

Race:

- American Indian or Alaska Native
- Asian or Pacific Islander
 - Asian
 - Native Hawaiian or Other Pacific Islander
- Black or African American
- White

Hispanic origin and race:

- Hispanic or Latino
- Not Hispanic or Latino
 - Black or African American
 - White

Gender:

- Female
- Male

Socioeconomic status:

Family income level-	or	Education level-
Poor		Less than high school
Near poor		High school graduate
Middle/high income		At least some college

The groups listed under most headings (race, Hispanic origin, gender, and income) in the minimum template are comprehensive; that is, they are intended to

sum to the population (excluding “unknowns”) tracked by the objective. For example, the three groups under income equal the total population tracked by the objective. The exception is the education category, which is limited to people of a minimum age or, in some cases, a maximum age (see Socioeconomic Status discussion below). The groups listed under the subheading “Not Hispanic or Latino” are not inclusive.

If data are not provided for a group, this is indicated by one of four statements: data have been collected but have not yet been analyzed (DNA), data are not collected by the data system used to track the objective (DNC), data are statistically unreliable (DSU), or the specific breakout is not applicable (NA). In cases where data for the entire template are not collected by the data system tracking the objective, a note to this effect will replace the template. For more information on statistical reliability, see section 9: Variability of Estimates.

Race and Hispanic Origin

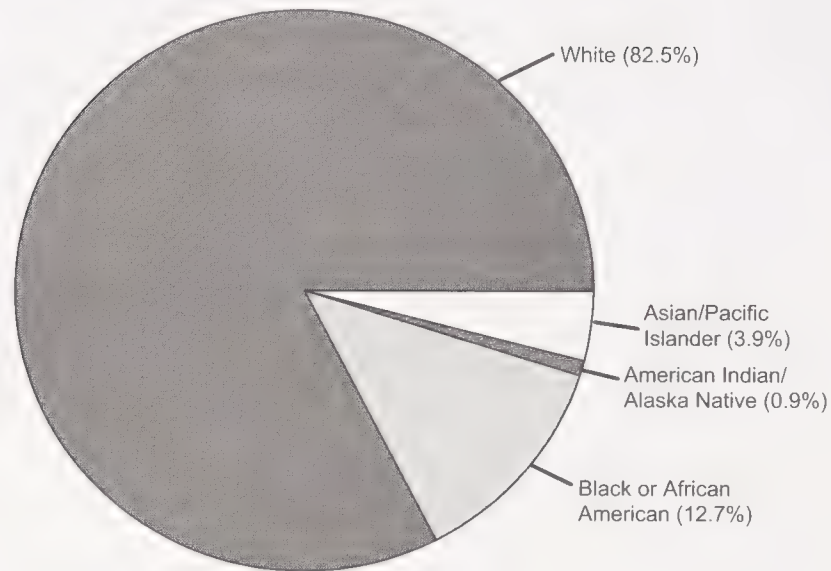
OMB Classification

On October 30, 1997, the Office of Management and Budget (OMB) published “Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity” (*Federal Register*, 62 FR 58781- 58790).² The new standards revise OMB Directive No. 15, adopted on May 12, 1977,³ and modify the data collection policy, making it possible for Federal agencies to collect information that reflects the increasing diversity of our Nation’s population stemming from growth in interracial marriages and immigration. As a result, the ways that data on race are tabulated and analyzed also will become more complex. Draft provisional tabulation guidelines, posted on the Internet at <http://www.whitehouse.gov/WH/EOP/OMB/html/misc-doc.html>, provide options for tabulating and for bridging between data collected under the old and new standards.⁴

The new standards are being used by the U.S. Census Bureau in the 2000 decennial census. Other Federal programs are adopting the standards as soon as possible, but not later than January 1, 2003, for use in household surveys, administrative forms and records, and other data collections.

OMB Directive No. 15, still in effect as tracking of the Healthy People 2010 objectives begins, defined the basic racial and Hispanic origin categories for Federal statistics and program administrative reporting as American Indian or Alaska Native, Asian or Pacific Islander, Black, White, and Hispanic.³ The distribution of the U.S. population in 1998 by race and Hispanic origin is shown in figures 2 and 3, respectively, using the OMB Directive No. 15 categories. Although baselines and the first few years of tracking are guided by OMB 15, sometime during the decade the race and Hispanic origin classifications for objectives will change. Change in the categories is not expected to happen all at once, but will be implemented incrementally as data systems adopt the new standards and, if applicable, denominator data from the Census Bureau for rates and percentages become available.

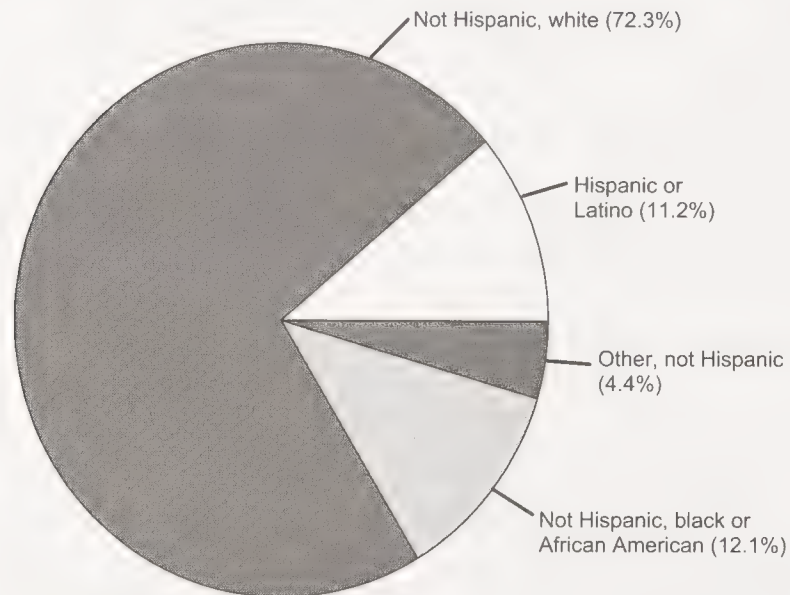
Figure 2. Resident population by race, United States, 1998.



Percents based on total population = 270,299,000

Source: U.S. Bureau of the Census, Population Estimates Program.

Figure 3. Resident population by Hispanic origin, United States, 1998.



Percents based on total population = 270,299,000

Source: U.S. Bureau of the Census, Population Estimates Program.

The major changes to the reporting of data on race and Hispanic origin under the new guidelines are (1) the instruction to “mark one or more” racial categories, and (2) the dividing of the “Asian or Pacific Islander” category into two separate categories— “Asian” and “Native Hawaiian or Other Pacific Islander.” The new OMB standards also call for tabulating data for multiple races. Because these guidelines have generally not yet been implemented by most major health data systems, data for more than one race are not shown. When data are available for more than one race for most of the major Healthy People 2010 data systems, they will be included in the tracking data. Also, most data systems currently do not produce data separately for the Asian and Native Hawaiian or Other Pacific Islander populations. Until data are tabulated for these groups, they will be shown as not collected.

Other changes include (1) “Hispanic” origin has been replaced by “Hispanic or Latino” (the preference remains for collecting these data in a separate question, the way it is presently being done on most Federal data collection forms), (2) Central and South American Indians, formerly not included in the “American Indian” category, are now included, and (3) the former “Black” category is replaced by “Black or African American.” Race and Hispanic origin may be reported in more detail for some objectives, subject to satisfying agency criteria for statistical reliability and confidentiality. For example, “Puerto Rican,” “Mexican,” and “Cuban” may be reported separately within the “Hispanic or Latino” group.

Under the new policy, agencies are required to offer respondents the option of selecting one or more of the following five racial categories included in the updated standards:

- **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Black or African American.** A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”
- **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

These five categories are the minimum set for data on race for Federal statistics, program administrative reporting, and civil rights compliance reporting. The new standards explicitly do not include an “other race” category for data collection; an “other” category may be used for tabulating and data reporting.³ Issues related to an “other” race category for census population data are discussed in section 3: Population Estimates. For Healthy People 2010, the designation “African American” will be used interchangeably with “Black or African American.”

The standards require that at a minimum, the total number of persons identifying with more than one race be reported when data are available. It is stressed that this is a minimum; the presentation of detailed information on specific racial combinations subject to constraints of data reliability and confidentiality standards is preferred. Based on preliminary research, it is estimated that less than 2 percent of the Nation’s total population is likely to identify with more than one race.³ Over time, this percentage may increase as those who identify with more than one race become aware of the opportunity to report more than one race group.

The standards regarding Hispanic origin provide for the collection of data on whether or not a person is of “Hispanic or Latino” culture or origin. This category is defined as follows:

Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish origin,” can be used in addition to “Hispanic or Latino.” Persons of Hispanic origin may be of any race and persons in the various race groups may be of any origin.

To provide flexibility and to assure data quality, the new OMB guidelines recommend that a two-question format (separate race and Hispanic ethnicity questions) be used, especially when self-identification is used. When race and ethnicity are collected separately, ethnicity should be collected first. Most Healthy People data systems that use self-identification, such as the National Health Interview Survey and the National Health and Nutrition Examination Survey, use the two-question format.

When self-identification is not feasible (for example, the National Notifiable Disease Surveillance System) or when there are overriding data collection considerations (for example, the Youth Risk Behavior Surveillance System), a combined race and ethnicity question can be used which includes a separate Hispanic category co-equal with the other (racial) categories. When a combined question is used, more than one entry (race and ethnicity or multiple races) is also possible.

Misreporting Racial and Ethnic Data

Most health survey and census population data use the self-reported race of the respondent, which is considered the most accurate representation of a person's racial or ethnic background. However, some data systems, such as the National Vital Statistics System (mortality), do not collect self-reported race or ethnicity of the decedent. In other systems, such as those derived from hospital/patient care records, it is often unclear whether the information is self-reported. In these cases, race and ethnicity may be entered by someone else (clerical staff, hospital personnel, etc.) based on the report of proxy respondents or by observation. Several of these data systems are discussed below.

National Vital Statistics System (Mortality)

Death rates by race and Hispanic origin may be biased from misreporting of race and Hispanic origin in the numerator of the rates and misreporting and undercoverage in the denominator of the rates.⁵ Numerator information is from the death certificate as reported by the funeral director based on information from an informant, usually a family member;⁶ while denominator information, from surveys or the Census of Population, is either self-reported or is reported by a member of the household. Based on comparisons of death certificate information with that from independent sources such as the Current Population Survey, the quality of reporting of race and Hispanic origin on the death certificate is good for the white and African American populations; however, reporting of other groups may be seriously under-reported.⁷ Additional reporting problems, such as net census undercount (see section 3: Population Estimates), affect population counts and estimates.⁸ As a consequence of the combined effect of numerator and denominator biases, it has been estimated that death rates for the white population are overestimated by about 1 percent and for the African American population by about 5 percent; and are underestimated for the American Indian or Alaska Native population by approximately 21 percent; Asian or Pacific Islanders, 11 percent; and Hispanics, 2 percent.⁵ These estimates are approximations; they do not take into account differential misreporting by age and sex among the race/ethnic origin groups.

For Healthy People 2010, infant mortality rates for races and ethnic populations are based on linked files of infant deaths and live births.⁹ These rates use the race of mother as self-reported on the birth certificate and, therefore, are not affected by the misreporting of race on the death certificate.

Patient Care Data

Data from systems that use patient records such as the National Hospital Discharge Survey (NHDS), the National Ambulatory Medical Care Survey, the National Hospital Ambulatory Medical Care Survey, the National Notifiable Disease Surveillance System, the HIV/AIDS Surveillance System, also may misreport the race of individuals. It is often unclear how race and ethnicity are reported in these systems. The race and ethnicity of the patient may be reported

by hospital or other medical care personnel by observation, by proxy report, or by the patient. Therefore, one must use information on race and ethnicity from these systems with caution.

Missing Data

In addition to the problems of misreporting race and ethnicity, the information on race reported by some data systems are often missing or incomplete. Some of these systems are described below. Specific information on the quality and completeness of reporting of race and ethnicity for the major Healthy People 2010 data systems is included, where available, in the data source description in Part C: Major Data Sources.

National Hospital Discharge Survey

Race is not reported in about 18 percent of NHDS records since data on race are not reported by many hospitals due to the omission of a race field on hospital discharge reporting forms.¹⁰ More hospitals have automated their discharge systems in recent years and are currently using form UB-92 which does not require race reporting. A comparison of NHDS data with data on persons who reported being hospitalized in the National Health Interview Survey (NHIS) (NHIS data were adjusted to exclude hospitalizations of 1 day or less) indicated that underreporting for the white patients was about 22 percent in 1991; the difference for African Americans was negligible.¹⁰ Hispanic origin is not reported for 85 percent of the NHDS records.

National Ambulatory Medical Care Surveys

For the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Care Survey, race is not reported for about 11 percent of records.

National Notifiable Disease Surveillance System

Although staff in State health departments and CDC attempt to obtain complete demographic information associated with nationally notifiable cases of disease, some data (particularly for the variables of race and ethnicity) are not available for some cases of disease. Laws, regulations, and mandates for public health reporting (including specific data items that are reported) fall under the authority of individual States, and in some States, race and ethnicity may not be approved for reporting to the national level. Race and ethnicity data may also be unknown when cases are reported from a laboratory or when cases are reported as aggregate disease totals.

Socioeconomic Status

One of the three overarching goals for the Healthy People 2000 prevention initiative was to reduce health disparities among Americans.¹¹ The proposed framework of Healthy People 2010 has taken this a step further by proposing to “eliminate health disparities” as one of the two primary goals for the next decade. While disparities among racial and ethnic groups—especially between whites and

African Americans—have received considerable attention over the last decade, differential health outcomes and access to social and health care resources often reflect differences in education, occupation, income, and wealth. Monitoring progress toward eliminating social and economic disparities in health over the next decade will require improved collection and use of standardized data on the socioeconomic status of individuals.

Socioeconomic status (SES) may be represented by income, level of education, or type of occupation. Healthy People 2010 primarily uses education and income-related measures. The following discussion presents data issues for income and education measures.

Income

Income is the most common measure of socioeconomic status, and is probably the most relevant to health policy formulation. Current income provides a direct measure of the quality of food, housing, leisure-time amenities, and health care an individual is able to acquire, as well as reflecting the relative position in society. However, income may fluctuate over time so that income received in a given year may not accurately reflect one's lifetime income stream or total wealth, the measures of resources more relevant to health. For example, elderly persons who have low incomes may also have accumulated assets that offset their need for a high annual income. Of particular importance in considering the relationship between income and health is the fact that income may be low because illness has limited the amount of income earned or prevented earning income entirely. The use of income as a measure of SES also involves more practical difficulties. In many health surveys a substantial number of persons either do not know or refuse to report their incomes.¹²

For most objectives, income reflects total family income for a given reference period, usually the previous 12 months or last calendar year. However, some data systems, such as the Continuing Survey of Food Intakes by Individuals (CSFII), use the income of the household (which includes income of unrelated household members). These systems generally require household income for program purposes. When household income is used instead of family income this is noted in the template for the objective.

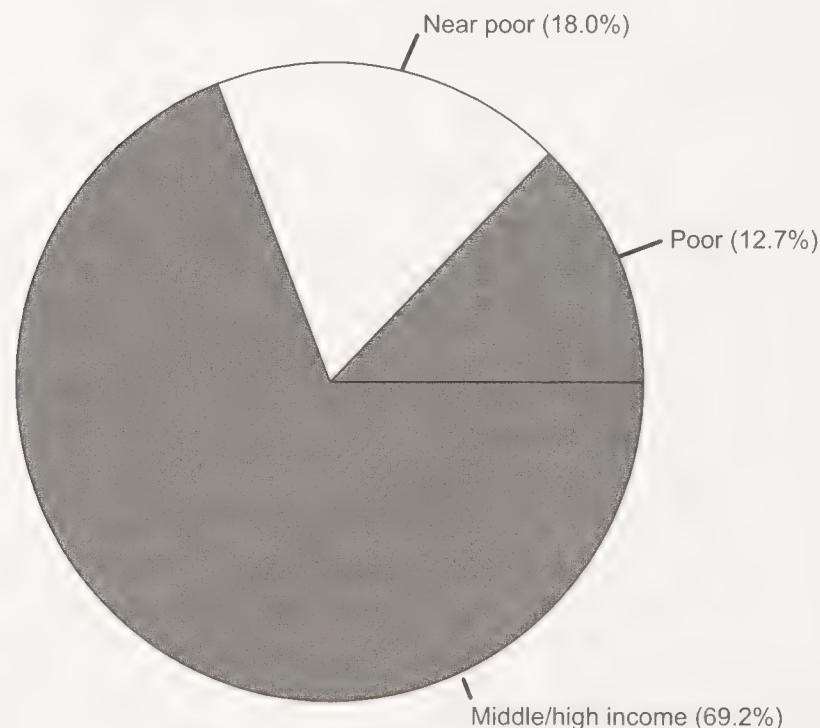
When income is selected for the template, poor, near poor, and middle/high income categories are used unless overridden by programmatic or data considerations (for example, Women, Infants, and Children (WIC) eligibility). In these special cases, the poverty categories appropriate for the program or system are used. For most health surveys, income is defined as money income before taxes and does not include the value of non-cash benefits such as food stamps, Medicare, Medicaid, public housing, and employer-provided fringe benefits.

Family Income Level

Converting income to poverty status adjusts for family size and inflation, facilitating comparisons among groups and over time. Poverty status measures family income relative to family size using the poverty thresholds developed by the U.S. Census Bureau, based on definitions originally developed by the Social Security Administration. These thresholds vary by family size and composition and are updated annually to reflect changes in the Consumer Price Index for all urban consumers. Families or individuals with income below their appropriate thresholds are classified as below the poverty level. Focusing simply on the dichotomy of “above” versus “below” poverty, however, obscures the full gradient of inequalities in income distribution and in health. Understanding burden across the income gradient provides information useful for potential eligibility expansions or other programmatic modifications. For Healthy People 2010, the three categories of family level income that are primarily used (see figure 4 for the distribution of population by poverty status) are:

- Poor (below the Federal poverty level),
- Near poor (100-199% of the Federal poverty level), and
- Middle and high income (200% or more of the Federal poverty level).

Figure 4. Poverty status for the civilian, noninstitutionalized population, United States, 1998.



Percents based on total population = 271,059,000 (as of March 1999)

Source: U.S. Bureau of the Census, Current Population Reports.

For a family of four, the average Federal poverty level weighted for family composition was \$16,813 in 1998. Table 1 shows the 1998 poverty thresholds by size of family and number of related children under 18 years.

Table 1. Poverty thresholds in 1998, by size of family and number of related children under 18 years.

Size of Family Unit	Related Children Under 18 Years								
	None	1	2	3	4	5	6	7	8
One person									
Under 65 years	8,480								
65 years and older	7,818								
Two persons									
Householder under 65 years	10,915	11,235							
Householder 65 years and older	9,853	11,193							
Three persons	12,750	13,120	13,133						
Four persons	16,813	17,088	16,530	16,588					
Five persons	20,275	20,570	19,940	19,453	19,155				
Six persons	23,320	23,413	22,930	22,468	21,780	21,373			
Seven persons	26,833	27,000	26,423	26,020	25,270	24,395	23,435		
Eight persons	30,010	30,275	29,730	29,253	28,575	27,715	26,820	26,593	
Nine persons or more	36,100	36,275	35,793	35,388	34,723	33,808	32,980	32,775	31,513

Note: Numbers represent income in U.S. dollars.

Source: U.S. Bureau of the Census.

In addition to the limitations discussed for income, converting income to poverty status introduces other issues that need to be considered. If income data are collected by selecting an appropriate income category, rather than giving the actual dollar amount, then the conversion to poverty status must be performed using category means or medians and will thus result in some misclassification.

The process of setting the official poverty definitions is currently being reevaluated. In 1990, a committee of the U.S. Congress requested that the National Academy of Science/National Research Council (NRC) conduct a study of the official poverty measure. In the final report issued in 1995, the NRC's Panel on Poverty and Family Assistance proposed a new approach for developing an operational definition of poverty. The proposed poverty measure would incorporate more broadly defined thresholds and a new definition of family resources (income) that includes the value of non-cash benefits such as food stamps, Medicare, Medicaid, public housing, and employer-provided fringe benefits and deducts work-related and medical expenses. The Census Bureau is currently conducting an extensive examination of the Panel's recommendations and alternative procedures. Revising the official U.S. poverty measure could have implications for data collection and trend analysis in Healthy People 2010.

Education

Education is frequently used as the measure of SES in presentations of health data. There are several reasons for this preference. Education is generally more completely reported than income; usually 95 percent or more of respondents report their attained level of education. Unlike occupation, all adults may be characterized by their education level. Education, unlike income or occupation, remains fixed for most people after the age of 25 and usually is not influenced by health. In addition, education is highly related to both income and occupation.

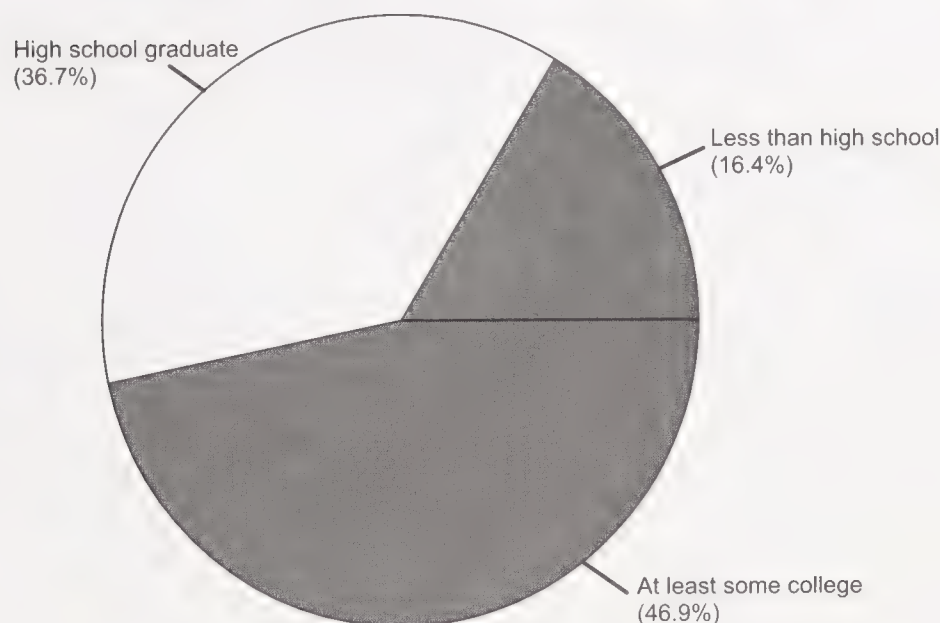
Education cannot be used to characterize the socioeconomic position of children (except through the educational level of parents or head of household), and the average education level of the U.S. population has increased steadily over time, complicating comparisons across age groups. Between 1971 and 1997, the educational attainment of persons aged 25 to 29 years completing high school rose from 78 to 87 percent; the percentage with some college rose from 44 to 65 percent; and the percentage with 4 or more years of college rose from 22 to 32 percent.¹³

Educational attainment is typically measured either by the number of years of education the individual has completed or by the highest credential received (see figure 5). The categories for educational attainment that are primarily used in Healthy People 2010 are:

- Less than high school (persons with less than 12 years of schooling or no high school diploma),
- High school graduate (persons with either 12 years of schooling, a high school diploma, or general equivalency diploma [GED], and
- At least some college (persons with a high school diploma or GED and 13 or more years of schooling).

In general, data on educational attainment are presented for ages beginning with 25 years, consistent with guidance given by the U.S. Census Bureau. However, objectives using different data systems may have different age groups for the education variable. The actual ages that are used to calculate educational attainment for some of the major Healthy People 2010 data systems are shown in Table 2. Because of the requirements of the different data systems, the age groups used to calculate educational attainment for an objective may differ from the age groups used to report the data for other select populations and the overall measure of the same objective. For clarity, each objective in Healthy People 2010 states the age groups used to measure the levels in the educational attainment category and caution must be used in comparing the data by educational attainment with data for the main objective and other select populations.

Figure 5. Educational attainment for the civilian, noninstitutionalized population aged 25 years and older, United States, 1998.



Percents based on total population aged 25 years and older = 172,211,000

Source: U.S. Bureau of the Census, Current Population Survey.

Healthy People 2010 baseline education data for the mortality objectives are based on reports from 46 States and the District of Columbia. Mortality statistics do not report data by education for the elderly population (65 years and older) because the percentage with “education not stated” is higher for this group and because of possible bias due to misreporting of education on the death certificate. Misreporting of education on the death certificate tends to overstate the death rate for high school graduates (12 years of education) because there is a tendency for some people who did not graduate from high school to be reported as high school graduates on the death certificate; by extension, the death rate for the group with less than 12 years of education tends to be understated.¹⁴

Table 2. Healthy People 2010 data systems and ages used to report educational attainment.

Data System	Ages Used To Report Educational Attainment
Behavioral Risk Factor Surveillance System (BRFSS)	25 years and older
National Health and Nutrition Examination Survey (NHANES)	25 years and older (unless otherwise noted)
National Health Interview Survey (NHIS)	25 years and older
National Survey of Family Growth (NSFG)	22–44 years
National Vital Statistics System—Mortality (NVSS-M)	25–64 years
National Vital Statistics System—Nativity and Linked (NVSS-N and NVSS-L)	20 years and older
National Household Survey on Drug Abuse (NHSDA)	18 years and older

Other Population Groups

Several other groups were considered for inclusion in the minimum set of select populations but were left to the discretion of the workgroups to include under specific objectives where appropriate. These groups included urban/rural residence, health insurance status, disability status, age, sexual orientation, the institutionalized population, and immigrant status, some of which are discussed in greater detail below. Some objectives also include select populations of persons with specific conditions—such as persons with diabetes, persons with hypertension, and persons with arthritis.

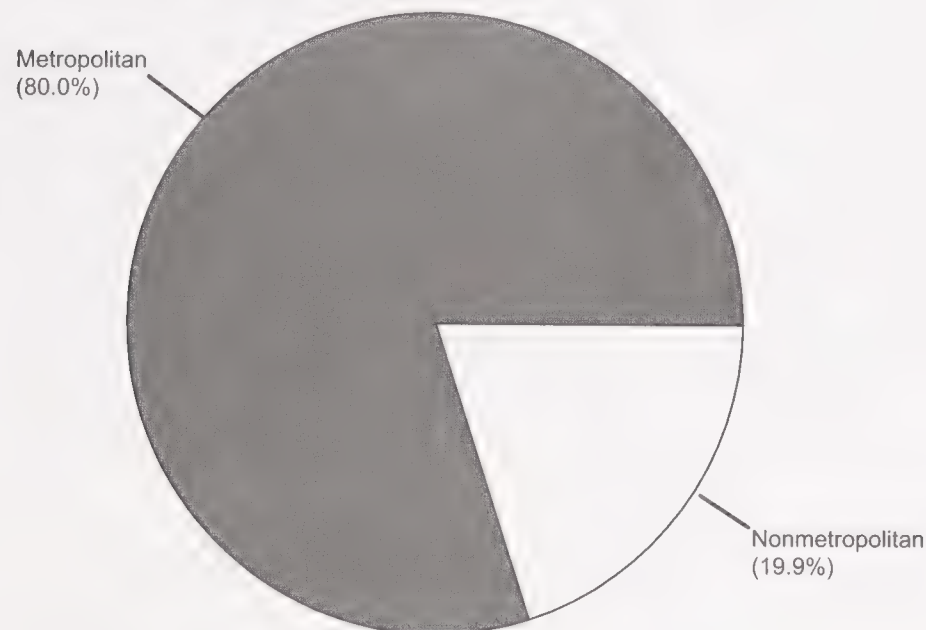
Urbanization

Urban residence in Healthy People 2010 is specified as either residing within or outside a metropolitan statistical area (MSA) or residing within or outside an urbanized area (UA) or urban place (called “urban” in the template) as designated by the U.S. Census Bureau (see figure 6 for a distribution of population by metropolitan and non-metropolitan residence).

Urban

Urban residence is defined as people living within the boundaries of an UA and the urban portion of places outside an UA that have a decennial census population of 2,500 or more. An UA is an area consisting of a central place(s) and adjacent urban fringe that together have a minimum residential population of at least 50,000 people and generally an overall population density of at least 1,000 people per square mile of land area. The U.S. Census Bureau uses published criteria to

Figure 6. Resident population living in metropolitan and nonmetropolitan areas, United States, 1998.



Percents based on total population = 270,298,524

Metropolitan defined as people living in metropolitan statistical areas

Source: U.S. Bureau of the Census, Population Estimates Program.

determine the qualification and boundaries of UA's. For more information see the Census Bureau Web site at <http://www.census.gov/geo/www/tiger/glossary.htm>.

Metropolitan Statistical Areas (MSA's)

Metropolitan statistical areas (MSA's) are established by the U.S. Office of Management and Budget (see figure 6). The MSA standards are revised before each decennial census. When census data become available, the standards are applied to define the actual MSA's. An MSA is a county or group of contiguous counties that contains at least one city with a population of 50,000 or more or includes a U.S. Census Bureau-defined urbanized area of at least 50,000 with a metropolitan population of at least 100,000. In addition to the county containing the main city or urbanized area, an MSA may contain other counties that are metropolitan in character and are economically and socially integrated with the central counties. In New England, cities and towns, rather than counties, are used to define MSA's. A rural residence, using the MSA standard, is defined as residing outside of an MSA. For further information on MSA's, see U.S. Department of Commerce, U.S. Census Bureau, *State and Metropolitan Area Data Book*.¹⁵

Health Insurance Status

Health insurance information applies only to persons aged under 65 years. Those 65 years and older are considered to be covered by Medicare. Respondents are considered to have health insurance if they are covered by either private or public

health plans. Private insurance includes fee-for-service plans, single service hospital plans, and coverage by health maintenance organizations (HMO's). Public insurance includes Medicaid or other public assistance, Aid for Families with Dependent Children (AFDC), Supplementary Security Income (SSI), Medicare, or military health plan coverage.

Disability

In 1980, the World Health Organization (WHO) published the first version of the International Classification of Impairments, Disabilities, and Handicaps (ICIDH) as a classification of the "consequences of disease." The new version, ICIDH-2, a classification of functioning and disability, is currently undergoing field testing worldwide with a May 2001 target date for implementation.¹⁶

According to ICIDH-2, components of disability include:

- losses or abnormalities of bodily function and structure (impairments),
- limitations of activities,
- restrictions in participation (formerly called handicaps),
- barriers and facilitators which make up the physical, social and attitudinal environment (environmental factors).

The major sources of national data on people with disabilities include:

- Decennial Census
- Survey of Income and Program Participation (SIPP)
- National Health Interview Survey (NHIS)
- National Health and Nutrition Examination Survey (NHANES)
- Medical Expenditure Panel Survey (MEPS)
- Current Population Survey (CPS)

For Healthy People 2010, the major sources of disability data are the NHIS and NHANES for national data and the Behavioral Risk Factor Surveillance System (BRFSS) for State-level data. The NHIS has several variables that can be used to operationally define disability status, including limitation of activity, restriction of participation (bed days, work-loss days, school-loss days), and assessed health status.¹⁷ The NHIS was redesigned in 1997 and many of the variables, especially limitation of activity, may be somewhat different than those collected by the survey before 1997. The BRFSS also collects information on health-related quality of life, limitation of activity, and self-assessed health status.

Disability is operationally defined in a number of different ways for program purposes and for analytic and research purposes, depending on the data collected by the data systems. In Healthy People 2010, disability is primarily defined using

information on activity limitation or the use of special equipment. The following are the definitions used for NHIS, BRFSS, and NHANES measures.

For the 1997 NHIS, a person is classified as having a disability if a “yes” response was obtained to any of the age-appropriate limitation questions or to the use of special equipment. (See the operational definition for the denominators used for objectives 6-2 (children) and 6-3 (adults) in Part B for the specific questions used from the 1997 NHIS.)

For NHIS data prior to 1997, the special equipment questions were not asked, so persons are categorized in the templates as “with activity limitation” rather than “with disabilities.”

State data are available from the BRFSS telephone surveys. For Healthy People 2010, using 1998 BRFSS data, people answering “yes” to any of the following questions define adults 18 years and older with disabilities:

- Are you limited in any way in any activities because of any impairment or health problem?
- If you use special equipment or help from others to get around, what type do you use?

Disability data from the NHANES are limited to the second phase of NHANES III (1991–94) and are calculated only for people 20 years and older. People are classified as having a disability if a “yes” response was obtained to any of the following questions:

- Are you limited in the kind or amount of work you can do because of any impairment or health problem?
- Are you limited in the kind or amount of housework you can do because of any impairment or health problem?
- Are you limited in any way in any activities because of any impairment or health problem?
- Do you usually use any device to help you get around such as a cane, wheelchair, crutches or walker?

The Centers for Disease Control and Prevention (CDC) has proposed that a standardized set of questions on disability status be developed. As standard questions are adopted by the data systems, the data produced from them will be incorporated into the Healthy People 2010 objectives that specifically identify people with disabilities. This presents the opportunity in the future to have a standard definition of people with disabilities that can be used across data systems and geographic levels. Objective 6-1 of Healthy People 2010 will track the incorporation of a standard definition in data systems used to monitor the Healthy People 2010 objectives.

To a large extent, disability measures are related to the generation of many summary measures discussed in the goals section of *Healthy People 2010: Understanding and Improving Health*.¹⁸ Summary measures of health generally combine information on mortality and health into a single measure. Many of these summary measures use variables that directly relate to disability status to generate the health component (often referred to as health-related quality of life) of the measure. Because of this, disability measures have importance beyond the assessment of the disability status of a population.

Age

Age is not included in the minimum template because to show inclusive age categories would add considerable complexity to the minimum set. Furthermore, age is often stated in the objective (for example, mammograms for females 40 years and older) and many objectives are relevant only for a subset of age groups. Age-specific select populations are added to objectives where needed and may not be inclusive of the total population. For example, data lines for the elderly, adolescents, or children have been added to some objectives without adding other groups, although showing inclusive age breakouts, if relevant, is preferred.

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5. Age Adjustment

Because many objectives in Healthy People 2010 have outcomes that vary by age, data for a number of objectives are age adjusted to control for differences due only to differences in age composition. Age adjustment, using the direct method, is the application of age-specific rates in a population of interest to a standardized age distribution in order to eliminate differences in observed rates that result from age differences in the population composition. This adjustment is usually done when comparing two or more populations (such as race/ethnic groups) at one point in time or one population at two or more points in time.

Age-adjusted rates are useful for comparison purposes only, not to measure absolute magnitude. (To compare absolute magnitude, numbers or crude rates are used.) The actual numerical value of an age-adjusted rate is dependent on the standard population used and, therefore, has no intrinsic meaning. Because age-adjusted rates are adjusted to a predetermined standard, they should be viewed as constructs or indexes rather than as direct or actual measures. It is important to note that in order to compare age-adjusted rates they must be adjusted to the same standard population.¹

For the Healthy People 2000 objectives, age adjustment was used for most of the mortality objectives and only for a very few selected other objectives. For Healthy People 2010, age adjustment is used again for most of the mortality objectives but also for many objectives that measure health outcomes and risk factors. Age-adjusted data may be shown for objectives that target either the total population or a groups with a large age range. Objectives or population subgroups that target groups with relatively small age ranges (generally less than 40 years) are not adjusted.

For some population groups, the age-adjusted rates are considerably different than crude rates. This happens because the population distribution of the group is quite different from the distribution of the standard population, which, for most objectives, is based on the projected year 2000 population for the entire United States. For example, for the Hispanic population (especially Mexican Americans) the age-adjusted rates for many outcomes and behaviors that are generally more frequent among the older population are considerably higher than the crude rates. This occurs because the Hispanic population has a much younger age distribution than the standard population.

Age-adjusted baseline data are noted in *Healthy People 2010*² and in Part B: Operational Definitions. Any data not specifically denoted as age adjusted, should be considered crude (unadjusted) data.

Mortality

There are about 40 Healthy People 2010 objectives that monitor mortality outcomes. Most of these objectives use data from the National Vital Statistics System (NVSS) of which 26 use death rates age adjusted by the direct method, to the 2000 standard population (see Appendix C). The other mortality objectives are measured using either:

- Numbers of deaths
- Age-specific death rates
- Maternal/infant rates, which use births as the denominator, or
- Crude death rates from other systems such as the Fatality Analysis Reporting System or the Census of Fatal Occupational Injuries

The details of measurement will be specified in the operational definition for each objective.

The age-adjusted death rate (AADR) is a weighted average of the age-specific death rates where the age-specific weights represent the relative age distribution of a standard population. The AADR is calculated by the direct method using the following formula:²

$$\text{AADR} = \sum w_{si} \cdot R_i$$

where R_i is the age-specific death rate for age interval i and w_{si} denotes the standard weight for age interval i such that

$$w_{si} = \frac{P_{si}}{\sum P_{si}}$$

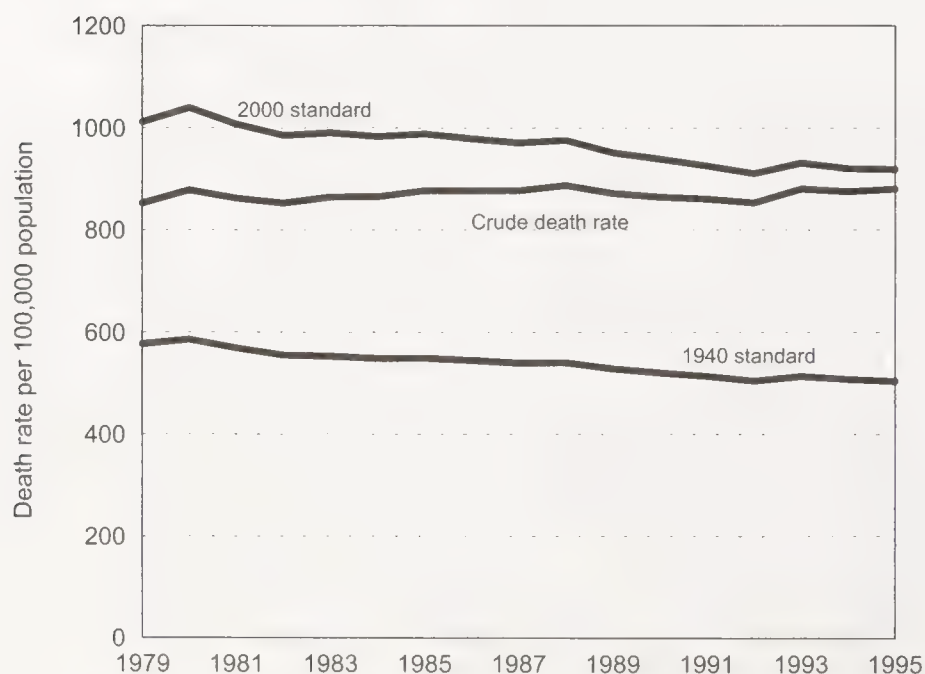
where P_{si} denotes the population in age interval i in the standard population, $0 < w_{si} < 1$, and the w_{si} sum to 1.

Selection of the standard age distribution, or standard population, is to some extent arbitrary.^{3,4} At least three different standards have been widely used over the years by Federal and State statistical agencies. Beginning with the analyses of data collected in 1999, all agencies of the U.S. Department of Health and Human Services (DHHS) will use a single standard based on a projection of the year 2000 U.S. population.^{5,6} Use of a single and more contemporary population standard helps reduce perceptions that the previously used standards are outdated, as well as confusion and misunderstanding among data users and the media when multiple data standards were used by the Department of Health and Human Services.⁵ Moreover, reflecting the current population structure, the new standard results in death rates that more closely approximate the average risk of death reflected in crude death rates.

Age-adjusted death rates for 1997 and 1998 used for Healthy People 2010 baseline data are based on the 2000 population standard. Therefore, they differ from rates shown in previous Healthy People 2000 reports,⁷ which show rates based on the 1940 standard population. Healthy People 2010 is showing rates adjusted to the 2000 standard before implementation of the new standard by most other agencies and publications. Therefore, the Healthy People 2010 baseline data will differ from those published in *Health, United States*, or the *National Vital Statistics Report*. To assist with the transition from the 1940 to the 2000 standard, the baseline 2010 rates adjusted to 1940 for the applicable mortality objectives are included in Appendix C.

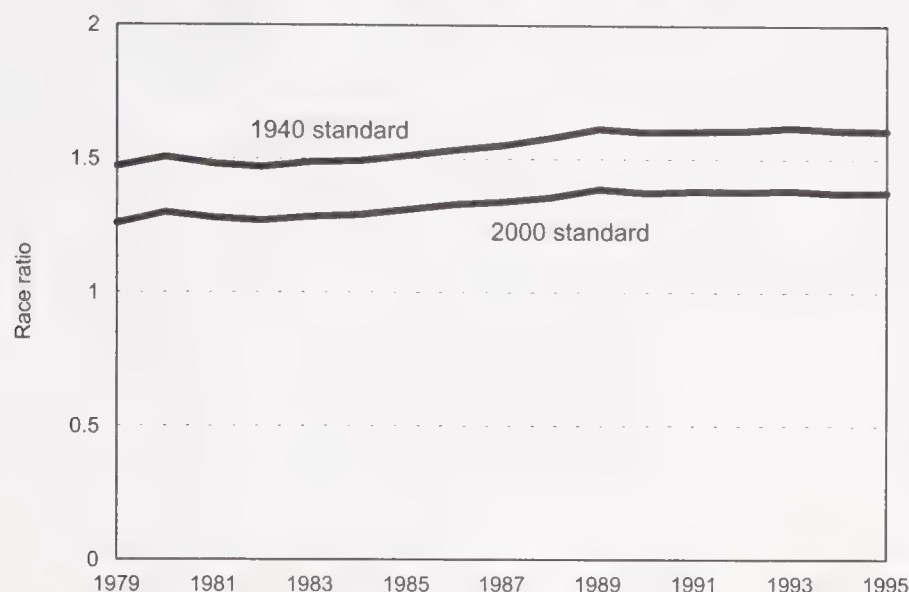
Changing to the 2000 standard has implications for the interpretation of mortality trends and comparisons. Figure 7 shows the trend in mortality for the crude death rate and the age-adjusted death rates based on the 1940 and 2000 standard.⁶ The age-adjusted death rate based on the 2000 standard for recent years much more closely reflects the observed average risk of mortality (represented by the crude death rate) than the rate adjusted to 1940. The age-adjusted rate based on the 2000 standard population is larger because the 2000 population, which has an older age structure than the 1940 population, gives more weight than the 1940 standard to death rates at the older ages where mortality is higher. The trend lines for the age-adjusted total mortality rates are roughly parallel, showing decreases in age-adjusted rates that are similar for the period 1979 through 1995. However, trends for some causes of death may differ. For Healthy People this means that the rates computed for Healthy People 2000 cannot be used in trend comparisons with rates computed for Healthy People 2010.

Figure 7. Crude and age-adjusted death rates based on the 1940 and 2000 standard populations, United States, 1979-95.



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

Figure 8. Mortality race ratio based on the 1940 and 2000 standard populations, United States, 1979-95.



Note: Race ratio = ratio of age-adjusted death rates for the African American population to that for the white population

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

Changing standards will affect comparisons between race and Hispanic groups. In particular, ratios of African American to white age-adjusted death rates are reduced from those based on the 1940 standard population, reducing the disparity between these two groups⁶ (see figure 8 above). This is due to the older age structure among the white population compared to the African-American population and greater weight given to death rates at the older ages. Comparisons between white and other minority groups may also be affected.

Comparisons should not be made between age-adjusted death rates based on different standards since the numerical value of the age-adjusted rate depends on the standard used; thus, age-adjusted death rates calculated before the implementation of the 2000 standard will not be comparable with rates based on the 2000 standard. Comparability requires recalculating the time series predating the new standard. For more detailed information regarding age adjustment and the implications of implementing the 2000 standard, refer to the National Center for Health Statistics (NCHS) publication "Age standardization of death rates: implementation of the 2000 standard,"⁶ which can be obtained at the following Internet address:

<http://www.cdc.gov/nchs/products/pubs/pubd/nvsr/>

The 2000 standard age distribution for mortality data along with corresponding values for w_{si} are shown in Table 3.

Table 3. 2000 standard million age distribution.

Age	Population (in thousands)	Standard Million	Proportion Distributions (w_{si})
All ages	274,634	1,000,000	1.000000
Under 1 year	3,795	13,818	0.013818
1-4 years	15,192	55,317	0.055317
5-14 years	39,977	145,565	0.145565
15-24 years	38,077	138,646	0.138646
25-34 years	37,233	135,573	0.135573
35-44 years	44,659	162,613	0.162613
45-54 years	37,030	134,834	0.134834
55-64 years	23,961	87,247	0.087247
65-74 years	18,136	66,037	0.066037
75-84 years	12,315	44,842	0.044842
85 years and older	4,259	15,508	0.015508

Source: U.S. Census Bureau, Population Estimates Program.

Health Surveys

A number of other Healthy People 2010 objectives use data from national health surveys that are also age adjusted. These are specified in Healthy People 2010² and in the operational definition for each objective. These include objectives tracked by the National Health Interview Survey (NHIS), the Medical Expenditure Panel Survey (MEPS), the National Hospital Discharge Survey (NHDS), the National Ambulatory Medical Care Survey (NAMCS), the National Hospital Ambulatory Medical Care Survey (NHAMCS), the Behavioral Risk Factor Surveillance System (BRFSS), the Continuing Survey of Food Intakes by Individuals (CSFII), and the National Health and Nutrition Examination Survey (NHANES). Data for these objectives are also age adjusted to the 2000 standard population, using the equations previously shown where R_i is the age-specific rate for the health status, health behavior, or health care utilization variable, as appropriate.

However, the age groups used to adjust the survey data may be somewhat different from those used to adjust mortality data. In general, to maximize the stability of the rates, fewer age groups are used. Differences resulting from the specific age groups used should be relatively small. In some cases, the applicable age range for the objective may not be the total population. For example, an objective may refer to persons aged 18 years and older, females aged 40 years and older, or persons aged 45-74 years, etc. In these cases, the weights are recomputed for applicable age groups so that they total to 1 (or 1,000,000).

The following age groups were used for the major data systems shown in Table 4. The specific grouping used depends on the age group targeted by the objective.

Table 4. Age groups used to age adjust from selected major Healthy People 2010 data systems.

Data System	Age Grouping				
	(All Ages)	(Ages 2+)	(Ages 18+)	(Ages 18+)	(Ages 25+)
NHIS	(All Ages)	(Ages 2+)	(Ages 18+)	(Ages 18+)	(Ages 25+)
BRFSS	0-17	2-17	18-24	18-24	25-34
MEPS	18-44	18-44	25-34	25-44	35-44
	45-54	45-54	35-44	45-64	45-64
	55-64	55-64	45-64	65+	65+
	65-74	65-74	65+		
	75+	75+			
	(Ages 40+)	(Ages 45+)	(Ages 50+)	(Ages 65+)	(Ages 0-17)
	40-49	45-49	50-64	65-74	0-4
	50-64	50-64	65+	75+	5-11
	65+	65+			12-17
	(Ages 18-64)				
NHANES CSFII	18-24				
	25-34				
	35-44				
	45-64				
	(All Ages)	(Ages 2+)	(Ages 18+)	(Ages 18+)	(Ages 25+)
	0-12	2-5	12-19	18-29	20-29
	12-19	6-11	20-29	30-39	30-39
	20-29	12-19	30-39	40-49	40-49
	30-39	20-29	40-49	50-59	50-59
	40-49	30-39	50-59	60-69	60-69
	50-59	40-49	60-69	70-79	70-79
	60-69	50-59	70-9	80+	80+
	70-79	60-69	80+		
	80+	70-79			
		80+			
	(Ages 20+)				
	20-39				
	40-59				
	60+				

Continued

Table 4. Age groups used to age adjust from selected major Healthy People 2010 data systems.

Data System		Age Grouping			
NAMCS NHAMCS	(All Ages)	(Ages 20+)			
	0-18	20-44			
	18-44	45-64			
	45-64	65+			
	65-74				
	75+				
NHDS	(All Ages)	(Ages 65+)	(Age 0-64)	(Ages 5-64)	
	0-18	65-74	0-17	5-17	
	18-44	75+	18-44	18-44	
	45-64		45-64	45-64	
	65-74				
	75+				

A reference list based on the projected 2000 population from which weights can be computed to age-adjust data for virtually all Healthy People 2010 objectives is shown below in Table 5:

Table 5. 2000 population projections by age (*in thousands*).

Age	Population	Age	Population
Total	274,634		
Under 1 year	3,795	30-34 years	19,511
1 year	3,759	35-39 years	22,180
2-4 years	11,433	40-44 years	22,479
5 years	3,896	45-49 years	19,806
6-8 years	11,800	50-54 years	17,224
9 years	4,224	55-59 years	13,307
10-11 years	8,258	60-64 years	10,654
12-14 years	11,799	65-69 years	9,410
15-17 years	11,819	70-74 years	8,726
18-19 years	8,001	75-79 years	7,415
20-24 years	18,257	80-84 years	4,900
25-29 years	17,722	85 years and older	4,259

Source: U.S. Bureau of the Census, Population Estimates Program.

More information on the age groups used to adjust and the weights used for specific data systems can be found in *Health, United States*.⁸

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6. Mortality and Morbidity Classification

Mortality Data

Baseline data for mortality objectives for specific causes of death in this report are classified and coded according to the World Health Organization's (WHO) Ninth Revision of the International Classification of Diseases (ICD-9)¹ that was implemented in the United States effective with deaths occurring in 1979. The specific ICD-9 codes used are included in the operational definition for each mortality objective. Beginning with deaths occurring in January 1999, the Tenth Revision of the ICD will be used (ICD-10).²

Since the beginning of the century, the ICD for mortality has been modified about once every 10 years, except for the 20-year interval between the last two revisions, ICD-9 and ICD-10. The purpose of the revisions is to stay abreast with medical advances in terms of disease nomenclature and etiology.

The ICD is a classification system for causes of death, which includes (1) coding rules for causes of death that allow a medical coder to identify the underlying cause of death on the death certificate that is considered most informative from a public health point of view; (2) definitions for concepts like "underlying cause of death;" (3) tabulation lists that indicate the cause-of-death groupings that countries should use to present mortality data that can be compared with other countries; and (4) the prescribed format of the medical certification section of the death certificate. Use of the ICD for classification and coding of mortality is required under an agreement between the United States and WHO.

Data for most Healthy People 2010 mortality objectives are based on the underlying cause of death. The underlying cause of death is defined by WHO as the disease or injury that initiated the sequence of events leading directly to death or as the circumstances of the violence or accident that produced the fatal injury.¹ It is selected from the conditions entered by the physician in the cause of death section on the death certificate. When more than one cause is entered by the physician, the underlying cause is determined by the sequence of conditions on the certificate, provisions of the ICD, and associated selection rules and modifications.³ Generally, more information is reported on the death certificate than is directly reflected in the underlying cause of death. This is captured in the multiple cause-of-death statistics. Several objectives use all mentions of a cause (or "multiple" cause) on the death certificate. Details on the ICD-9 codes used for the baseline for the Healthy People 2010 objective and whether the data used are underlying or multiple cause will be found in the operational definition for each mortality objective and also summarized in Appendix D.

ICD-10 differs from ICD-9 in a number of respects: (1) ICD-10 is far more detailed than ICD-9, about 8,000 categories compared with 4,000 categories,

mainly to provide more clinical detail for morbidity (illness) applications; (2) ICD-10 uses 4-digit alpha-numeric codes compared with 4-digit numeric codes in ICD-9; (3) three additional chapters have been added, some chapters rearranged, cause of death titles have been changed, and conditions have been regrouped; and (4) some coding rules have been changed.

The ICD-10 cause-of-death categories are reflected in ICD-10 tabulation lists created by the National Center for Health Statistics (NCHS) in collaboration with other Federal agencies and the States. A total of eight tabulation lists were developed for ICD-10, the most detailed of which includes each of the 4-digit categories that are valid for underlying cause of death. Replacing the widely used ICD-9 list of 72 selected causes of death plus HIV and Alzheimer's is the ICD-10 tabulation list of 113 Selected Causes of Death. This list, which will be used to identify and rank the leading causes of death, will also be used, wherever possible, to track the Healthy People 2010 mortality objectives.

The lists are published in the NCHS Instruction Manual, Part 9.⁴ They can be accessed through the NCHS mortality Web site at the following address:

<http://www.cdc.gov/nchs/about/major/dvs/im.htm>

Introduction of a new revision of the ICD creates discontinuities—some serious—in time series trends for causes of death, because of the reclassification of diseases and changes in the coding rules. Therefore, the causes of death used for the 1997 and 1998 baselines in the initial Healthy People 2010 report will not be strictly comparable with the tracking data for 1999 and subsequent years.

When graphically displaying mortality data across revisions of the ICD, it is helpful if trend lines be broken at the point in time that the new ICD revision was introduced to emphasize the discontinuities resulting from the change in revision.³ The extent of the discontinuity is measured using a “comparability ratio,” which results from double-coding a large sample of the national mortality file, once by the old revision (ICD-9), and again by the new revision (ICD-10), and expressing the results of the comparison as a ratio of deaths for a cause of death by the later revision divided by the number of that cause of death coded and classified by the earlier revision.⁵ Preliminary comparability ratios for causes of death between ICD-9 and ICD-10 will be published by NCHS in the year 2000. In subsequent Healthy People 2010 reports, information will be provided on the comparability of the ICD-9 baseline data and the ICD-10 tracking data for Healthy People 2010 objectives that are affected.

The NCHS Web site for ICD-10 for mortality is as follows:

<http://www.cdc.gov/nchs/about/major/dvs/icd10des.htm>

Data for the Healthy People 2000 mortality objectives were also coded according to ICD-9, although in a few cases, the specific codes used for the 2010 objectives are different from those used for the comparable Healthy People 2000 objective.

These differences are noted in the operational definition for the objective in Part B: Operational Definitions.

Morbidity Data

Baseline data for morbidity objectives from sources such as the National Hospital Discharge Survey, National Ambulatory Medical Care Survey, and the National Hospital Ambulatory Care Survey are coded to International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).⁶ The specific ICD-9-CM codes used will be included in the operational definition for each morbidity objective.

ICD-9-CM is a clinical modification of the WHO's International Classification of Diseases, 9th Revision (ICD-9). The term "clinical" is used to emphasize the modification's intent to serve as a useful tool in the area of classification of morbidity data for indexing of hospital medical records, medical care review, and ambulatory and other medical care programs, as well as for basic health statistics. ICD-9-CM provides greater specificity at the fifth digit level of detail, which goes beyond the three and four digit level of ICD-9.

ICD-9-CM is used to code and classify morbidity data from inpatient and outpatient records, physicians' offices, long term care facilities and most health surveys. ICD-9-CM is compatible with its parent classification (ICD-9), thus meeting the need for comparability of morbidity and mortality statistics.

Additional codes and code changes were made to the ICD-9-CM beginning in 1986. A conversion table for diagnosis and procedure code changes between 1986 and 1998 is available to assist users in data retrieval. The table shows the date the new code became effective and its previously assigned code equivalent. The latest additions to the classification appear in bold print. The conversion table may be found on the NCHS Web site at the following address:

<http://www.cdc.gov/nchs/dataawh/ftpserv/ftp9/ftp9.htm#conv>

Code assignment using ICD-9-CM is based on official national coding guidelines. The guidelines for selecting the "first-listed" or principal diagnosis for morbidity records differ from those used in coding death records to select the underlying cause of death. Under morbidity coding rules, the first listed or principal diagnosis is that condition established after study to be chiefly responsible for occasioning the admission to the hospital or the encounter with the health care provider for care. In some instances the principal diagnosis may be a manifestation of the disease rather than the underlying cause. For example, if a patient with a primary malignant neoplasm with metastasis is admitted to receive treatment directed toward a secondary site, the secondary site would be designated on the hospital discharge form as the principal diagnosis.

For Healthy People 2010, the principal ("first-listed") diagnosis is generally used to track the morbidity objectives. However, in some cases "all-listed" diagnoses,

which include the principal and all other diagnoses appearing on the medical record, are used (as many as 7 to 10 diagnoses may appear in some records). Details on the specific ICD-9-CM diagnoses used are noted in the operational definition for each applicable objective and are summarized in Appendix E.

The official coding guidelines are available on the NCHS morbidity Web site at the following address:

<http://www.cdc.gov/nchs/datawh/ftpserve/ftp9icd9/ftp9icd9.htm#guide>

A clinical modification of ICD-10 (ICD-10-CM) has been developed as a replacement for ICD-9-CM, however, as of this writing, an implementation date had not been designated. Once implemented, revised coding guidelines, training materials and crosswalks between ICD-9-CM and ICD-10-CM will be made available on the NCHS Web site.

Data for the Healthy People 2000 morbidity objectives from the sources listed above were also coded according to ICD-9-CM, although in a few cases, the specific codes used for the 2010 objectives are different from those used for the comparable Healthy People 2000 objective. These differences are noted in the operational definition for the objective in Part B: Operational Definitions.

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7. National Data

Data used to track the Healthy People 2010 objectives are based on events occurring in the 50 States and the District of Columbia, where available. Unless specifically noted, all objectives exclude data for U.S. territories. The data used to track most population-based Healthy People 2010 objectives are derived from either a national census of events (for example, National Vital Statistics System, National Notifiable Disease Surveillance System, Fatality Analysis Reporting System) or from nationally representative sample surveys (for example, National Health Interview Survey, National Household Survey on Drug Abuse, School Health Policies and Programs Study).

For some objectives, however, complete national data are not available and data for selected States and/or areas are used to monitor the objectives. In these cases, the coverage area is described with the data for the objective and in the operational definitions. Examples of these data systems include the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), the Adult Spectrum of Disease Project (ASD), the Health Care Cost and Utilization Project (HCUP), and the Toxic Exposure Surveillance System (TESS). Data for these objectives may not be representative of the United States as a whole. If during the decade national data become available, they will be used to track the objectives.

For some national data systems that cover the entire United States, such as the Behavioral Risk Factor Surveillance System and the National Vital Statistics System, data are not available for some variables for all States. This is either because data for a specific variable are not collected by some States or because the quality of data for some States is not sufficient to produce reliable estimates for some variables. Some examples are shown in Table 6, with the number of States reporting in the baseline data year. The number of reporting States can vary from year to year. This information is also shown in the operational definitions for selected objectives.

Table 6. Variables in major data systems for which data are not available from all States.

Data System	Variable	Number of States With Data Available
National Vital Statistics System (Mortality)	Education	46 States + District of Columbia (1998)
National Vital Statistics System (Natality)	Maternal smoking	46 States + District of Columbia and New York City (1998)
Behavioral Risk Factor Surveillance System	Diabetes variables	39 States (1998)
Behavioral Risk Factor Surveillance System	Disability	11 States + District of Columbia (1998)

8. State and Local Data

Healthy People has provided a framework for national, State, and local health agencies and non-governmental organizations to assess health status, health behaviors, and services and to plan and evaluate health promotion programs.^{1, 2} The national Healthy People initiatives have served as a “menu” for identifying State and local priorities and selecting objectives that are most relevant to specific States, communities, and specific settings (schools, worksites, etc.), and health care delivery systems.^{3, 4} By using the national Healthy People initiative as a common point of departure, agencies and organizations have tailored programs targeted toward their customers, yet retained a common basis for evaluating performance in relation to both the nation, other States, or populations.⁵

This focus on performance has prompted State and local health agencies to shift from their emphasis of primarily providing services to one that conducts needs assessment and quality assurance.^{6, 7} This shift has required increased collection and analysis of data. Health care delivery organizations have also experienced this shift and have increased efforts to collect standardized data on patients, services, and outcomes.⁸ The increased emphasis on data collection and analysis for purposes of assessment and evaluation has increased the need to address the associated issues of data availability, validity/reliability, comparability, and utilization. These issues also affect the relevance of the national Healthy People objectives at the State and local level. The large number and diversity of State and local health agency structures and resources amplify the impact of these data issues when trying to compare Healthy People plans, objectives, and progress among States or between a State and the nation. States also vary considerably in their capacity to monitor the objectives they identify as most relevant to their constituents.⁹ Some key areas where these issues need to be examined at State and local levels are discussed below.

Objective Wording/Operational Definition

The Healthy People “menu” provides a useful way for States and localities to focus on serious health issues, but many agencies and organizations have tailored the objectives to better focus on specific concerns of their constituents. These modifications may more effectively address the health concerns of the State or local population, but they also reduce comparability when evaluating objective progress relative to the nation, other States, or localities.¹⁰

Population Data/Race and Ethnicity Reporting

Many Healthy People objectives are population based and are expressed in terms of mortality or morbidity rates (for example, lung cancer deaths per 100,000), where the denominator is a population estimate. National, State, and local health agencies primarily rely on population estimates produced by the U.S. Census Bureau. The Bureau produces estimates for the nation, States, counties, and large

municipalities during the decennial census and has provided annual post-censal estimates since 1990 (see section 3: Population Estimates). These estimates are provided by gender, age, and race and ethnicity (see section 4: Population Template). However, the sizes of some racial groups (American Indian or Alaska Native and Asian or Pacific Islander) are relatively small, even at the national level, and are distributed unevenly across State and local areas. This precludes many jurisdictions from producing reliable rates for objectives that focus on these populations.

“Rare” Events/Confidentiality

Some Healthy People objectives (for example, suicide or HIV deaths) address important, sensitive health issues which are, fortunately, relatively rare events. Reporting small numbers of suicides or HIV deaths in a county or municipality with a small population may produce unreliable, nonrepresentative rates. Reporting these rates by certain characteristics, including geocoding and displaying maps of the distribution of sensitive or rare events, also may jeopardize confidentiality. It may be necessary to aggregate data over geographic areas, personal characteristics, and/or data years to address both of these problems.

Age Adjustment

In general, States and localities age-adjust mortality data to the same standard population used for the national data (see section 5: Age Adjustment). However, because Healthy People 2010 is implementing the 2000 standard population ahead of the recommended schedule (see section 5, Age Adjustment), there may be a period of time when the State mortality data do not match the Healthy People 2010 data.

Data Sources

The availability and comparability of data for national, State, and local monitoring of Healthy People objectives vary considerably. Some data, especially vital statistics, are readily available at national, State, county, and some municipal levels. The standardization of vital statistics data contributes to its comparability across jurisdictions. Because they are readily accessible and generally comparable, mortality and natality data were key parts of the 18 Health Status Indicators (HSI) selected for widespread State and local use in Healthy People 2000.¹¹ However, vital statistics data provide only a limited perspective on health status, risk behaviors, and access to health care. Morbidity and risk factor data are required to monitor a very large proportion of the current and proposed Healthy People objectives. Data for these objectives come from a wide range of household surveys, environmental hazard data, and other sources.

Many of the national Healthy People objectives are monitored using data from the National Health Interview Survey (NHIS). Some of these objectives are monitored at State and some local levels using data from the Behavioral Risk

Factor Surveillance System (BRFSS). Details of these surveys (for example, design, sampling) are described in Part C: Major Data Sources. In general, however, it should be noted that both differences in the data collection methods (household interview versus telephone interview) and wording of questions used to monitor the same objectives can affect the comparability of the information collected. Additionally, some objectives monitored with identical questions in both the NHIS and the BRFSS (for example, firearm storage) are only included periodically in a specific rotating module of the BRFSS or supplements to the NHIS. Not all States use these modules or the year of the “rotation” may not coincide with national data from the NHIS. This limits comparability between national and State data.

Other national Healthy People objectives are monitored using composite data sources (for example, General Estimates System, National Water Quality Trends Report). The national data from these systems are aggregated from data collected at State or local levels. Unlike the vital statistics data (which include all births and deaths), several of these systems are samples of events that use somewhat different data collection and analysis methods between States or between communities.¹² This affects the quality and comparability of national, State, and local data.

For other Healthy People objectives, State and local jurisdictions were unable to monitor progress. This prompted the development of Priority Data Needs under Healthy People 2000,¹³ which identified sources of State and local data that could be used to track important health issues, such as adult immunization and access to primary health care. During the development of the Healthy People 2010 objectives, participants proposed that a set of Leading Health Indicators be selected to further improve national, State, and local agencies’ abilities to measure and evaluate health status and programmatic activity.¹⁴ The availability of data for the Leading Health Indicators may be somewhat limited at the State level and it represents a substantial challenge for measurement at the local level.

References

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2. American Public Health Association. *Healthy Communities: Guidelines for Community Attainment of the Year 2000 National Health Objectives*. Washington, DC: the Association, 1991.
3. Public Health Service (PHS). *Promoting Health/Preventing Disease: Objectives for the Nation*, Washington, DC: U.S. Department of Health and Human Services (HHS), 1980.
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5. Twenty-two percent of the objectives included in the HHS agency’s strategic plan (developed in accordance with the Government Performance and Results Act of 1993) were adopted from Healthy People 2000 (see Office of Disease Prevention and Health

Promotion. *HHS Leading Indicators for Healthy People 2010: A report from the HHS Working Group on Sentinel Objectives*. Washington, DC: HHS, 1998).

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8. Many health care organizations have adopted the use of the Health Employer Data Information System (HEDIS) as a mechanism to standardize the collection of data and to evaluate outcomes. (See National Committee for Quality Assurance Web site: <<http://www.ncqa.org>>.)

9. The Public Health Foundation reports that in 1997, States reported an average ability to measure 39 percent of the Healthy People 2000 objectives. (See Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey*, Washington, DC: the Foundation, 1998.) To focus on the need to develop capacity for tracking at the State and local level, Healthy People 2010 includes a separate focus area aimed at improving infrastructure and surveillance capability. (See Office of Public Health and Science. *Healthy People 2010: Objectives for Improving Health*. Washington, DC: HHS, 1998.)

10. For example, there is a national objective calling for increased testing and mitigation of homes for threats from radon. Some States have adopted this objective verbatim, whereas others also have included schools or day care centers within the same objective related to home testing. Additionally, the operational definitions used for the same or similar national and State/local objectives may vary considerably. The national radon objective is monitored using self-report data from a household survey, whereas some States use data based on actual installation of radon monitors and picocurie information collected.

11. Freedman, M.A. *Health Status Indicators for the Year 2000*. Statistical Note No. 1. Hyattsville, MD: NCHS, 1991.

12. For example, the National Water Quality data are compiled from State data on "assessed" rivers, lakes, and estuaries. States vary in the proportions and the specific bodies of waters they assess across time. Hence, both State and national estimates may be subject to considerable variation.

13. Kim, I., and Keppel, K.K. *Priority Data Needs: Sources of National, State, and Local-Level Data and Data Collection Systems*. Statistical Note No.15. Hyattsville, MD: NCHS, 1997.

14. HHS. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

9. Variability of Estimates

For many health outcomes, assessing all individuals in a population may be impossible, impractical, expensive, or inaccurate. Therefore, it is usually advantageous to study a sample of the original population.¹ Much of the data used to monitor the Healthy People 2010 objectives are derived from sample surveys (for example, National Health Interview Survey, National Survey of Family Growth, National Household Survey on Drug Abuse, National Health and Nutrition Examination Survey, Youth Risk Behavior Surveillance System) that make estimates for a population from a representative sample of respondents. These estimates are subject to sampling variation or sampling error. The standard error is a measure of sampling error and represents the variations that can occur by chance since only a sample of the population is surveyed rather than the entire population. Assuming a normal distribution of events, the chances are about 68 in 100 that an estimate from the sample would differ from a complete census by less than the standard error. The chances are about 95 in 100 that the difference would be less than twice the standard error. This is often referred to as the 95 percent confidence interval, where the estimate is expressed as a range of the observed rates, approximately ± 1.96 standard errors.

Some of the data (for example, vital statistics, infectious disease incidence) used to track the Healthy People 2010 objectives are based on complete counts. As such, they are not subject to sampling error, although they are subject to errors in the registration process. However, when the estimates are used for analytical purposes, such as the comparison of rates over a period of time or for different groups or areas, the number of events that actually occurred may be considered as one of a large series of possible results that could have arisen under the same circumstances. This is generally known as random variation. When the number of events is large, random variation is usually small. However, when the number of events is small (fewer than 100) and the probability of such an event is small, random variation can be substantial and considerable caution must be used in interpreting the change described by the estimates. In these cases, it is desirable to compute the standard error of the estimates and use that computation in the comparison of interest. More information on random variation and small numbers can be found in the *Vital Statistics of the United States*.²

To properly interpret differences between rates for different groups or changes over time derived from sample surveys, it is important to consider the sampling variation associated with each rate. Healthy People 2010 specifies the use of a population template that includes detailed racial, ethnic, and socioeconomic breakouts for all population-based objectives (see section 4: Population Template). Therefore, some objectives show data for relatively small population groups. These data may be associated with large standard errors and, therefore, apparent differences between population groups or between a population group in the template and the total population may be within expected sampling or random error. Standard errors should be considered when evaluating progress or

comparing population groups for objectives using survey data. For ease of presentation, the standard errors associated with the estimates for the Healthy People 2010 objectives do not appear in either *Healthy People 2010*³ or *Tracking Healthy People 2010*. However, where available, they will be included in the Healthy People 2010 database (see section 10: Healthy People 2010 Database). More information on the sample design and variance estimation for some of the major data systems used to monitor the Healthy People 2010 objectives can be found in Part C: Major Data Systems and in other publications.^{4, 5, 6, 7, 8, 9, 10, 11, 12, 13}

If the data for any group are considered statistically unreliable, “DSU” (data are statistically unreliable) is shown in the cell in place of the data in *Healthy People 2010*³ and in the Healthy People 2010 database (see section 10, Healthy People 2010 Database). DSU is used to address a number of situations that produce unreliable data that vary by data system. For a number of Healthy People 2010 sample survey data systems (for example, NHIS and NHANES), a figure is considered unreliable if it has a relative standard error (RSE) of greater than 30 percent. For vital statistics data that are based on complete counts, a figure is considered unreliable if it is based on fewer than 20 events. Data may also be considered unreliable if there are a large number of unknown entries or if the sampling frame cannot produce representative estimates for a particular group.

For most objectives, the data are for single years. However, for some objectives (or subgroups in the population template) that are based on relatively few events, multiple years of data are used to produce more stable estimates.

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10. Healthy People 2010 Database

The Healthy People 2010 database, called “DATA2010,” can be accessed through the CDC/WONDER system found on the Internet at <http://wonder.cdc.gov/data2010> or through the NCHS Web site at <http://www.cdc.gov/nchs>. Through DATA2010 the user can create tables that contain the baseline and tracking data for each of the Healthy People 2010 objectives and the Leading Health Indicators.

Tables can be constructed by selecting an entire Healthy People 2010 focus area (with or without related objectives in other focus areas), by selecting an objective within a focus area, or by selecting an objective from a keyword search that will search for all objectives containing a specific word or phrase. Users can also select all data for population subgroups such as race, ethnicity, gender, SES status, etc. Once tables are generated they can be exported in either ASCII, comma-delimited, or HTML format for use in common software applications such as Lotus 1-2-3 and SAS.

These Web sites also allow users to obtain other Healthy People 2010 information, such as full text of the objectives, lead agency contacts for each focus area, and information on Healthy People 2010 progress reviews.

Database Description

DATA2010 is a SAS database that contains one record (or observation) for each objective and subpart found in the 28 focus areas. The database will also contain records for the measures used to track the goals and the Leading Health Indicators.

Each record in the database contains the following information:

- Objective number
- Objective text (abbreviated)
- Baseline year
- Baseline data
- Tracking data for subsequent years (future)
- 2010 Target
- Comments (definitions, clarifications, and explanations)
- Data source(s)

Future Plans

In the future, DATA2010 will contain additional population groups, and include options for chart and map generation. State data are expected to be added to the database, and users will be able to select national and/or State data. There also will be links to the operational definitions in *Tracking Healthy People 2010* and to the Healthy People 2010 Web site <http://health.gov/healthypeople>. Where available, standard errors of the estimates will be included in the database

Part B:

Operational Definitions

An operational definition for each Healthy People 2010 objective is shown in this section, organized by focus area. Some of the objectives have more than one statistical measure. For these objectives operational definitions are shown separately for each measure. In this section, both the 467 Healthy People 2010 objectives and their subparts are referred to as “objectives.”

These definitions are provided to assist in the interpretation of the data presented for each Healthy People 2010 objective and to facilitate comparable measurement of these objectives by researchers from the national, State, and local government agencies as well as those from private organizations. A contact for each objective is listed in Appendix A; this contact can provide further information, if necessary.

The first page of each focus area includes a list of objectives (short text) and subobjectives. The operational definitions include the following elements about the baseline data for each Healthy People 2010 objective and subobjective measure:

- Full text of the objective
- National data source
- State data source
- Healthy People 2000 objective (see below)
- Leading Health Indicator (if applicable, see below)
- Type of measure (percent, rate, number, etc.)
- Baseline data
- Numerator
- Denominator
- Population targeted
- Survey questions used to obtain the data (if applicable)
- Expected periodicity (of the statistical measure)
- Additional comments

The operational definitions shown this section are as complete as possible at the time of publication. For all objectives with measurable Healthy People 2010 baseline data, the operational definition is either complete, partially complete, or not known. If the operational definition is complete all elements will be filled out appropriately. If the operational definition is either partially complete or not known, all available information is shown in the “Comments” area.

In each operational definition there is a description of the comparability of the objective to the Healthy People 2000 objectives. Each Healthy People 2010 objective measure is identified as either (a) identical to a Healthy People 2000 objective, identified with the Healthy People 2000 objective number; (b) identical to a Healthy People 2000 objective, except for a change in calculation

methodology (for example, age adjustment to the 2000 standard population where the comparable Healthy People 2000 objective was either not adjusted or adjusted to a different standard), identified with the Healthy People 2000 objective number and the new calculation methodology in parentheses; (c) adapted from a Healthy People 2000 objective, with changes in the type of measure, definition, or data source, identified with “adapted from Healthy People 2000 objective ___”; or (d) as having no counterpart in Healthy People 2000, identified with “Not applicable.”

If the objective was adapted from a Healthy People 2000 objective, the differences between the objectives are described in the Comments section of the operational definition. If the comparable Healthy People 2000 objective was duplicated in more than one priority area, the primary objective number is shown, with the duplicate objective numbers shown in parentheses. Several reports have been published showing the operational definitions for the objectives in selected Healthy People 2000 priority areas.^{1, 2, 3, 4, 5, 6} Complete crosswalks between the Healthy People 2000 objectives and the Healthy People 2010 objectives are shown in Appendices F and G. Healthy People 2000 objectives and comparable Healthy People 2010 objectives that are different in any way (either condition (b) or (c) in the paragraph above), are noted as “adapted” in the Comments section of Appendices F and G.

Objective measures that have been designated as measures for the Leading Health Indicators will include an entry called “Leading Health Indicator” that will show the name of the Leading Health Indicator category (for example, Access to Care, Injury and Violence, Mental Health). A list of Leading Health Indicators, their measures, and the corresponding Healthy People 2010 objective number is shown in Appendix H.

Unless specifically noted otherwise, data for the numerator and denominator of the objective measures exclude unknown and refused responses. Where applicable, the questions used to obtain the national baseline data are shown in the operational definition. Items shown in italics with the symbol “>” are actual questions from the original survey instrument. Interviewer instructions and other notes from the survey instrument are shown in italics without the symbol. Notes to guide the user that were not part of the original survey instrument are shown in brackets without italics.

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1

Access to Quality Health Services

Clinical Preventive Care

- 1-1 Persons with health insurance
- 1-2 Health insurance coverage for clinical preventive services
- 1-3 Counseling about health behaviors
 - 1-3a Physical activity or exercise
 - 1-3b Diet and nutrition
 - 1-3c Smoking cessation
 - 1-3d Reduced alcohol consumption
 - 1-3e Childhood injury prevention: vehicle restraints and bicycle helmets
 - 1-3f Unintended pregnancy
 - 1-3g Prevention of sexually transmitted diseases
 - 1-3h Management of menopause

Primary Care

- 1-4 Source of ongoing care
 - 1-4a All ages
 - 1-4b Children and youth aged 17 years and under
 - 1-4c Adults aged 18 years and older
- 1-5 Usual primary care provider
- 1-6 Difficulties or delays in obtaining needed health care
- 1-7 Core competencies in health provider training
- 1-8 Racial and ethnic representation in health professions
 - 1-8a American Indian or Alaska Native—Health professions
 - 1-8b Asian or Pacific Islander—Health professions
 - 1-8c Black or African American—Health professions
 - 1-8d Hispanic or Latino—Health professions
 - 1-8e American Indian or Alaska Native—Nursing
 - 1-8f Asian or Pacific Islander—Nursing
 - 1-8g Black or African American—Nursing
 - 1-8h Hispanic or Latino—Nursing

- 1-8i American Indian or Alaska Native—Medicine
- 1-8j Asian or Pacific Islander—Medicine
- 1-8k Black or African American—Medicine
- 1-8l Hispanic or Latino—Medicine
- 1-8m American Indian or Alaska Native—Dentistry
- 1-8n Asian or Pacific Islander—Dentistry
- 1-8o Black or African American—Dentistry
- 1-8p Hispanic or Latino—Dentistry
- 1-8q American Indian or Alaska Native—Pharmacy
- 1-8r Asian or Pacific Islander—Pharmacy
- 1-8s Black or African American—Pharmacy
- 1-8t Hispanic or Latino—Pharmacy
- 1-9 Hospitalization for ambulatory-care-sensitive conditions
- 1-9a Pediatric asthma
- 1-9b Uncontrolled diabetes
- 1-9c Immunization-preventable pneumonia or influenza

Emergency Services

- 1-10 Delay or difficulty in getting emergency care
- 1-11 Rapid prehospital emergency care
- 1-12 Single toll-free number for poison control centers
- 1-13 Trauma care systems
- 1-14 Special needs of children
- 1-14a Online medical direction
- 1-14b Guidelines

Long-Term Care and Rehabilitative Services

- 1-15 Long-term care services
- 1-16 Pressure ulcers among nursing home residents

Clinical Preventive Care

1-1. Increase the proportion of persons with health insurance.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 21.4 (Clinical Preventive Services).
Leading Health Indicator	Access to Health Care.
Measure	Percent (age adjusted—see Comments).
Baseline	83 (1997).
Numerator	Number persons under age 65 years who report coverage by any type of public or private health insurance.
Denominator	Number of persons under age 65 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	For questions from the 1997 National Health Interview Survey, Family core, Section IV, Health Insurance, see: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/1997/qfamilyx.pdf .
Expected Periodicity	Annual.
Comments	<p>Health care coverage includes any type of health insurance or health care plan, including those obtained by employment, direct purchase, and Government programs, including Medicare, Medi-Gap, military healthcare/VA, Medicaid, CHAMPUS/TRICARE/CHAMP-VA, Indian Health Service, State-sponsored health plans, or other public hospital or physician programs.</p> <p>More information on the definition of health insurance coverage is provided by <i>Health, United States, 2000</i>.¹</p>

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

This measure is a modification of its comparable Healthy People 2000 objective 21.4, which proposed to improve the financing and delivery of clinical preventive services. Healthy People 2000 objective 21.4 was tracked by a proxy measure: the proportion of persons with no health care coverage.² This objective tracks the converse measure, the proportion of persons with health care coverage and does not specifically address delivery of clinical preventive services (see objective 1-2). Also, this objective is age adjusted; the Healthy People 2000 objective was not.

This objective is one of the measures used to track the Access to Health Care Leading Health Indicator. See Appendix H for a complete listing.

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



1-2. (Developmental) Increase the proportion of insured persons with coverage for clinical preventive services.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the Medical Expenditure Panel Survey (MEPS), AHRQ (formerly AHCPH). The 1996 MEPS data are currently being analyzed and may provide baseline data on percent of persons with coverage for selected preventive services (well-child visits, immunizations, mammograms, cervical cancer screening, and adult physicals).

The numerator will be the number of persons who have coverage for clinical preventive services as part of their health insurance. The denominator will be the number of insured persons.

These data are based on an abstract of the respondents' insurance policies, rather than household reports.

This objective is a modification of Healthy People 2000 objective 21.4, which proposed to improve the financing and delivery of clinical preventive services (see Comments provided with objective 1-1 for more information).

Data will be collected periodically, with as much as a 3-year lag time in reporting these data.

Data that are collected periodically from policy booklets obtained from MEPS household respondents could be modified to collect information on a broader set of preventive services.

Recommended services to track include childhood and adult immunizations; recommended cancer screening (breast, cervix, and colon); smoking cessation counseling; and contraceptive services.

See Part C for a description of MEPS and Appendix A for focus area contact information.



1-3. Increase the proportion of persons appropriately counseled about health behaviors.

1-3a. (Developmental) Physical activity or exercise (adults aged 18 years and older).

Comments

An operational definition could not be specified at time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

This objective is a modification of Healthy People 2000 objective 1.12, which tracked the proportion of clinicians who counseled 81 to 100 percent of their patients about physical activity and was tracked using the Primary Care Providers Surveys, OPHS, ODPHP, and the Prevention in Primary Care Study, American College of Preventive Medicine. This measure will track adults aged 18 years and older with a physician visit in the past year and is scheduled to be tracked using NHIS, CDC, NCHS.

The proposed questions to be used to obtain the data are scheduled for inclusion in the 2001 NHIS.

See Part C for a description of NHIS and Appendix A for focus area contact information.



1-3b. (Developmental) Diet and nutrition (adults aged 18 years and older).

Comments

An operational definition could not be specified at time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

This objective is a modification of Healthy People 2000 objective 2.21, which tracked the proportion of clinicians who counseled 81 to 100 percent of their patients about nutrition and diet; it was tracked using the Primary Care Providers Surveys, OPHS, ODPHP and the Prevention in Primary Care Study, American College of Preventive Medicine. This measure will track adults aged 18 years and older with a physician visit in the past year, who received counseling on diet and nutrition; the measure is scheduled to be tracked using the National Health Interview Survey, CDC, NCHS.

The proposed questions to be used to obtain the data are scheduled for inclusion in the 2001 NHIS.

See Part C for a description of NHIS and Appendix A for focus area contact information.



1-3c. (Developmental) Smoking cessation (adult smokers aged 18 years and older).

Comments

An operational definition could not be specified at time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

This objective is a modification of Healthy People 2000 objective 3.16, which tracked the proportion of clinicians who counseled 81 to 100 percent of their patients about smoking cessation, and was tracked using the Primary Care Providers Surveys, OPHS, ODPHP and the Prevention in Primary Care Study, American College of Preventive Medicine. This measure will track adults aged 18 years and older with a physician visit in the past year who are current smokers or who have quit smoking in the past 12 months; the measure is scheduled to be tracked using the National Health Interview Survey, CDC, NCHS.

The proposed questions to be used to obtain the data are scheduled for inclusion in the 2001 NHIS.

See Part C for a description of NHIS and Appendix A for focus area contact information.



1-3d. (Developmental) Reduced alcohol consumption (adults aged 18 years and older with excessive alcohol consumption).

Comments

An operational definition could not be specified at time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

This objective is a modification of Healthy People 2000 objective 4.19, which tracked the proportion of clinicians who counseled 81 to 100 percent of their patients about drug and alcohol use; it was tracked using the Primary Care Providers Surveys, OPHS, ODPHP and the Prevention in Primary Care Study, American College of Preventive Medicine. This measure will track adults aged 18 years and older with a physician visit in the past year who have reported excessive alcohol consumption; the measure is scheduled to be tracked using the National Health Interview Survey, CDC, NCHS.

The proposed questions to be used to obtain the data are scheduled for inclusion in the 2001 NHIS.

See Part C for a description of NHIS and Appendix A for focus area contact information.



1-3e. (Developmental) Childhood injury prevention: vehicle restraints and bicycle helmets (children aged 17 years and under).

Comments

An operational definition could not be specified at time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

This objective is a modification of Healthy People 2000 objective 9.21, which tracked the proportion of clinicians who counseled 81 to 100 percent of their patients about injury prevention; the objective was tracked using the Primary Care Providers Surveys, OPHS, ODPHP and the Prevention in Primary Care Study, American College of Preventive Medicine. This measure will track children aged 17 years and under who are reported to have had a physician visit in the past year and received counseling on the use of vehicle restraints and bicycle helmets, using the National Health Interview Survey, CDC, NCHS.

The proposed questions to be used to obtain the data are scheduled for inclusion in the 2001 NHIS.

See Part C for a description of NHIS and Appendix A for focus area contact information.



1-3f. Unintended pregnancy (females aged 15 to 44 years).

National Data Source	National Survey on Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 14.12 (Maternal and Infant Health) (also 5.10).
Measure	Percent.
Baseline	19 (1995).
Numerator	Number of women aged 15 to 44 years with a physician visit in the past 12 months who received counseling on either birth control or getting sterilized.
Denominator	Number of women aged 15 to 44 years with a physician visit in the past 12 months.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1995 National Survey on Family Growth:

- *In the past 12 months, that is since (month/year), have you received any of the following birth control services from a doctor or other health care provider?*
- Counseling about birth control or a prescription for a method?*
- Counseling about getting sterilized?*

Expected Periodicity

Periodic.

Comments

Women were considered to receive counseling if they responded “yes” to either receiving counseling about birth control or getting sterilized.

This objective is a modification of Healthy People 2000 objective 14.12, which tracked the proportion of clinicians who counseled 81 to 100 percent of their patients about family planning; it was tracked using the Primary Care Providers Surveys, OPHS, ODPHP and the Prevention in Primary Care Study, American College of Preventive Medicine.

See Part C for a description of NSFG and Appendix A for focus area contact information.



1-3g. (Developmental) Prevention of sexually transmitted diseases (males aged 15 to 49 years, females aged 15 to 44 years).

Comments

An operational definition could not be specified at time of publication.

The proposed national data source is the National Survey on Family Growth (NSFG), CDC, NCHS.

This objective is a modification of Healthy People 2000 objective 18.9 (also 19.14), which tracked the proportion of clinicians who counseled 81 to 100 percent of their patients about prevention of HIV and other sexually transmitted diseases; the objective was tracked using the Primary Care Providers Surveys, OPHS, ODPHP and the Prevention in Primary Care Study, American College of Preventive Medicine.

The 2001 NSFG will collect data on STD counseling for men aged 15 to 49 years. While the NSFG does collect data on family planning services for women aged 15 to 44 years [including the receipt of birth control services (including condoms)], specific

questions on STD counseling among women currently are not included.

See Part C for a description of NSFG and Appendix A for focus area contact information.



1-3h. (Developmental) Management of menopause (females aged 46 to 56 years).

Comments

An operational definition could not be specified at time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS. The proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

This measure is a modification of Healthy People 2000 objective 17.18, which tracked the proportion of perimenopausal women aged 40 to 60 years who were counseled about estrogen replacement therapy. This measure will track women aged 46 to 56 years who have had a physician visit in the past year and report that they have received counseling on management of menopause.

The proposed questions to be used to obtain the data are scheduled for inclusion in the 2001 NHIS.

See Part C for a description of NHIS and Appendix A for focus area contact information.



Primary Care

1-4. Increase the proportion of persons who have a specific source of ongoing care.

1-4a. All ages.

National Data Source

National Health Interview Survey (NHIS), CDC, NCHS.

State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 21.3 (Clinical Preventive Services), age adjusted to the 2000 standard population.
Leading Health Indicator	Access to Health Care.
Measure	Percent (age adjusted—see Comments).
Baseline	87 (1998).
Numerator	Number of persons who report having a specific source of primary care.
Denominator	Number of persons.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <ul style="list-style-type: none"> ➤ <i>Is there a place that you usually go when you are sick or need advice about your health?</i> ➤ <i>What kind of place is it: a clinic, doctor's office, emergency room, or some other place?</i> <ul style="list-style-type: none"> (a) <i>Hospital emergency room</i> (b) <i>Urgent care/walk-in clinic</i> (c) <i>Doctor's office</i> (d) <i>Clinic</i> (e) <i>Health center facility</i> (f) <i>Hospital outpatient clinic</i> (g) <i>HMO (Health Maintenance Organization)/Pre-paid group</i> (h) <i>Military or other VA healthcare</i> (i) <i>Some other place</i>
Expected Periodicity	Annual.
Comments	<p>A specific source of primary care includes responses (b) through (i) listed above. A hospital emergency room (a) is not included as a specific source of primary care.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p> <p>This measure is modified from its comparable Healthy People 2000 objective 21.3, which tracked persons aged 18 years and older. This measure tracks persons of all ages and is age adjusted to the 2000 standard population.</p>

This objective is one of the measures used to track the Access to Health Care Leading Health Indicator. See Appendix H for a complete listing.

See Part C for a description of NHIS and Appendix A for focus area contact information.



1-4b. Children and youth aged 17 years and under.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 21.3 (Clinical Preventive Services).
Measure	Percent (age adjusted—see Comments).
Baseline	93 (1998).
Numerator	Number of children and youth aged 17 years and under who report having a specific source of primary care.
Denominator	Number of children and youth aged 17 years and under.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-4a.
Expected Periodicity	Annual.
Comments	<p>A specific source of primary care includes responses (b) through (i) listed in the Questions Used To Obtain the National Data provided with objective 1-4a, above. A hospital emergency room (a) is not included as a specific source of primary care.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p>

This measure is modified from its comparable Healthy People 2000 objective 21.3, which tracked persons aged 18 years and older. This measure tracks children and youth aged 17 years and under and is age adjusted to the 2000 standard population.

See Part C for a description of NHIS and Appendix A for focus area contact information.



1-4c. Adults aged 18 years and older.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	21.3 (Clinical Preventive Services), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	85 (1998).
Numerator	Number adults aged 18 years and older who report having a specific source of primary care.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-4a.
Expected Periodicity	Annual.
Comments	<p>A specific source of primary care includes responses (b) through (i) listed in the Questions Used To Obtain the National Data provided with objective 1-4a above. A hospital emergency room (a) is not included as a specific source of primary care.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p>

See Part C for a description of NHIS and BRFSS,
and Appendix A for focus area contact information.



1-5. Increase the proportion of persons with a usual primary care provider.

National Data Source	Medical Expenditure Panel Survey (MEPS), AHRQ (formerly AHCPR).
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	77 (1996).
Numerator	Number of persons who report that they have a usual primary care provider.
Denominator	Number of persons.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1996 Medical Expenditure Panel Survey:</p> <ul style="list-style-type: none">➤ <i>Is there a particular doctor's office, health center, or other place that (<u>Person</u>) usually goes if (<u>Person</u>) is sick or needs advice about (<u>Person</u>)'s health?</i>➤ <i>Is (<u>Provider</u>) the (person/place) they would go for new health problems?</i>➤ <i>Is (<u>Provider</u>) the (person/place) they would go for preventive health care, such as general checkups, examinations, and immunizations?</i>➤ <i>Is (<u>Provider</u>) the (person/place) they would go for referrals to other health professionals when needed?</i>
Expected Periodicity	Annual.

Comments

Persons were determined to have a usual primary care provider if they reported that they would usually go to the same health professional for all four of the following situations: if they were sick or needed advice about their health; if they had new health problems; if they needed preventive care such as general checkups, examinations, and immunizations; and if they needed referrals to other health professionals. Persons who reported an emergency room as their usual source of care were classified as not having a usual primary care provider.

See Part C for a description of MEPS and Appendix A for focus area contact information.



1-6. Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members.

National Data Source	Medical Expenditure Panel Survey (MEPS), AHRQ (formerly AHCPR).
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	12 (1996).
Numerator	Number of families that report that at least one family member had difficulty or delay in obtaining health care or did not receive needed care.
Denominator	Number of families.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1996 Medical Expenditure Panel Survey:

- *In the last 12 months, did anyone in the family experience difficulty in obtaining any type of health care, delay in obtaining care, or not receive health care they thought they needed due to any of the reasons listed below?*
- (1) Couldn't afford care*
 - (2) Insurance company wouldn't approve, cover, or pay for care*
 - (3) Pre-existing condition*
 - (4) Insurance required a referral, but couldn't get one*
 - (5) Doctor refused to accept family's insurance plan*
 - (6) Medical care too far away*
 - (7) Can't drive/don't have car/ no public transportation available*
 - (8) Too expensive to get there*
 - (9) Hearing impairment or loss*
 - (10) Different language*
 - (11) Hard to get into building*
 - (12) Hard to get around inside building*
 - (13) No appropriate equipment in office*
 - (14) Couldn't get time off work*
 - (15) Didn't know where to go to get care*
 - (16) Was refused services*
 - (17) Couldn't get child care*
 - (18) Didn't have time or took too long*
 - (19) Other*

Expected Periodicity

Annual.

Comments

A family is considered having difficulty in obtaining care if the head of household responds “yes” to any of the options (1 through 19) listed in the question above.

See Part C for a description of MEPS and Appendix A for focus area contact information.



1-7. (Developmental) Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the Adaptation of the Prevention Self-Assessment Analysis, ATPM.



1-8. In the health professions, allied and associated health profession fields, and the nursing field, increase the proportion of all degrees awarded to members of underrepresented racial and ethnic groups.

1-8a. American Indian or Alaska Native—health professions and allied and associated health profession fields.

National Data Sources Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; *AAMC Data Book*, Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.

State Data Sources Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; *AAMC Data Book*, Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.

Healthy People 2000 Objective 21.8 (Clinical Preventive Services).

Measure Percent.

Baseline 0.6 (1996–97).

Numerator Number of degrees in the health professions (medicine, dentistry, pharmacy, and public health) and allied and associated health profession fields awarded to American Indian or Alaska Native persons.

Denominator Number of degrees awarded by accredited schools to all persons in the health professions and allied and associated health profession fields.

Population Targeted Students in accredited health professions and allied and associated health profession schools.

Questions Used To Obtain the National Data

Not applicable for data collected on pharmacy degrees and public health degrees.

For medical degrees, see *AAMC Data Book*.²

For dental degrees, from the 1997–98 Survey of Predoctoral Dental Education Institutions:

- *How many students received a D.D.S. or D.M.D. degree between October 1, 1996 and September 30, 1997?*
(Total must equal the total number of graduates listed on the graduate class list.)
- *How many students received a D.D.S. or D.M.D. degree between October 1, 1996 and September 30, 1997 in each of the following race/ethnicity categories?*

	Male	Female	Total
a. White	_____	_____	_____
b. Black	_____	_____	_____
c. Hispanic	_____	_____	_____
d. Native American	_____	_____	_____
e. Asian	_____	_____	_____
f. Not Indicated	_____	_____	_____
Total	_____	_____	_____

(Total must equal the total number of graduates listed on the graduate class list.)

Expected Periodicity

Annual.

Comments

This measure includes only U.S. citizens in its tabulation of public health degrees.³ Dental degrees include both D.D.S. and D.M.D.⁴ Pharmacy degrees include both doctor of pharmacy degrees awarded as the first professional degree and postbaccalaureate degrees.⁵ Medical degrees include only M.D. graduates.²

This measure combines data from four sources that collect data on accredited schools; the data are tabulated by the Bureau of Health Professions (BHP), HRSA.

See Appendix A for focus area contact information.



1-8b. Asian or Pacific Islander—health professions and allied and associated health profession fields.

National Data Sources	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; <i>AAMC Data Book</i> , Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
State Data Sources	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; <i>AAMC Data Book</i> , Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
Healthy People 2000 Objective	21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	16.2 (1996–97).
Numerator	Number of degrees in the health professions (medicine, dentistry, pharmacy, and public health) and allied and associated health profession fields awarded to Asian and Pacific Islander persons.
Denominator	Number of degrees awarded by accredited schools to all persons in the health professions and allied and associated health profession fields.
Population Targeted	Students in accredited health professions and allied and associated health profession schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-8a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8a for more information.



1-8c. Black or African American—health professions and allied and associated health profession fields.

National Data Sources	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; <i>AAMC Data Book</i> , Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
State Data Sources	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; <i>AAMC Data Book</i> , Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
Healthy People 2000 Objective	21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	6.7 (1996–97).
Numerator	Number of degrees in the health professions (medicine, dentistry, pharmacy, and public health) and allied and associated health profession fields awarded to black or African American persons.
Denominator	Number of degrees awarded by accredited schools to all persons in the health profession and allied and associated health profession fields.
Population Targeted	Students in accredited health professions and allied and associated health profession schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-8a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8a for more information.



1-8d. Hispanic or Latino—health professions and allied and associated health profession fields.

National Data Sources	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; <i>AAMC Data Book</i> , Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
State Data Sources	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; <i>AAMC Data Book</i> , Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
Healthy People 2000 Objective	21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	4.0 (1996–97).
Numerator	Number of degrees in the health professions (medicine, dentistry, pharmacy, and public health) and allied and associated health profession fields awarded to black or African American persons.
Denominator	Number of degrees awarded by accredited schools to all persons in the health professions and allied and associated health profession fields.
Population Targeted	Students in accredited health professions and allied and associated health profession schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-8a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8a for more information.



1-8e. American Indian or Alaska Native—nursing.

National Data Source	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
State Data Source	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
Healthy People 2000 Objective	Adapted from 21.8a (Clinical Preventive Services).
Measure	Percent.
Baseline	0.7 (1995–96).
Numerator	Number of degrees in nursing awarded by accredited schools to American Indian or Alaska Native persons.
Denominator	Number of degrees awarded by accredited schools to all persons in nursing.
Population Targeted	Students in accredited nursing schools.
Questions Used To Obtain the National Data	<p>From the 1999 Annual Survey of RN (Registered Nurse) Programs:</p> <ul style="list-style-type: none">➤ <i>Total Enrollments</i> <i>Ethnic/Racial distribution (all students):</i> _____ American Indian/Alaskan Native _____ Asian/Pacific Islander _____ Black, Non-Hispanic _____ Hispanic _____ White, Non-Hispanic _____ Unknown (The total of the numbers above should equal the total enrollment.)➤ <i>Total Graduations</i> <i>Ethnic/Racial distribution (number):</i> _____ American Indian/Alaskan Native _____ Asian/Pacific Islander _____ Black, Non-Hispanic _____ Hispanic _____ White, Non-Hispanic _____ Unknown (The total of the numbers above should equal the total graduations.)
Expected Periodicity	Annual.

Comments

Nursing degrees in basic nursing education include diploma, associates degree, and basic baccalaureate degree.⁶ Data exclude degrees awarded to students in American Samoa, Guam, and Puerto Rico.

This measure is modified from its comparable Healthy People 2000 objective 21.8a, which tracked the number of people enrolled in schools of nursing. This measure tracks the degrees awarded by nursing schools to unrepresented racial and ethnic minority groups.

See Appendix A for focus area contact information.

**1-8f. Asian or Pacific Islander—nursing.**

National Data Source	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
State Data Source	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
Healthy People 2000 Objective	Adapted from 21.8a (Clinical Preventive Services).
Measure	Percent.
Baseline	3.2 (1995–96).
Numerator	Number of degrees in nursing awarded by accredited schools to Asian or Pacific Islander persons.
Denominator	Number of degrees awarded by accredited schools to all persons in nursing.
Population Targeted	Students in accredited nursing schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-8e.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8e for more information.



1-8g. Black or African American—nursing.

National Data Source	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
State Data Source	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
Healthy People 2000 Objective	Adapted from 21.8a (Clinical Preventive Services).
Measure	Percent.
Baseline	6.9 (1995–96).
Numerator	Number of degrees in nursing awarded by accredited schools to black or African American persons.
Denominator	Number of degrees awarded by accredited schools to all persons in nursing.
Population Targeted	Students in accredited nursing schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-8e.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8e for more information.



1-8h. Hispanic or Latino—nursing.

National Data Source	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
State Data Source	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
Healthy People 2000 Objective	Adapted from 21.8a (Clinical Preventive Services).
Measure	Percent.
Baseline	3.4 (1995–96).

Numerator	Number of degrees in nursing awarded by accredited schools to Hispanic or Latino persons.
Denominator	Number of degrees awarded by accredited schools to all persons in nursing.
Population Targeted	Students in accredited nursing schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-8e.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8e for more information.



1-8i. American Indian or Alaska Native—medicine.

National Data Source	<i>AAMC Data Book</i> , Association of American Medical Colleges.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	0.6 (1996–97).
Numerator	Number of degrees awarded by accredited allopathic medical schools to American Indian or Alaska Native persons.
Denominator	Number of degrees awarded by accredited allopathic medical schools to all persons.
Population Targeted	Students in accredited allopathic medical schools.
Questions Used To Obtain the National Data	See <i>AAMC Data Book</i> . ²
Expected Periodicity	Annual.
Comments	Data are obtained through annual surveys completed by accredited medical schools and are aggregate counts of the number of graduates with an M.D. degree. ²

This objective is a modification of the Healthy People 2000 objective 21.8, which tracked the proportion of degrees awarded in all health professions (medicine, pharmacy, dentistry, and public health). This measure tracks the proportion of degrees awarded in medicine only.

See Appendix A for focus area contact information.



1-8j. Asian or Pacific Islander—medicine.

National Data Source	<i>AAMC Data Book</i> , Association of American Medical Colleges.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	15.9 (1996–97).
Numerator	Number of degrees awarded by accredited allopathic medical schools to Asian or Pacific Islander persons.
Denominator	Number of degrees awarded by accredited allopathic medical schools to all persons.
Population Targeted	Students in accredited allopathic medical schools.
Questions Used To Obtain the National Data	See <i>AAMC Data Book</i> . ²
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8i for more information.



1-8k. Black or African American—medicine.

National Data Source	<i>AAMC Data Book</i> , Association of American Medical Colleges.
State Data Source	Not identified.

Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	7.3 (1996–97).
Numerator	Number of degrees awarded by accredited allopathic medical schools to black or African American persons.
Denominator	Number of degrees awarded by accredited allopathic medical schools to all persons.
Population Targeted	Students in accredited allopathic medical schools.
Questions Used To Obtain the National Data	See <i>AAMC Data Book</i> . ²
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8i for more information.



1-8l. Hispanic or Latino—medicine.

National Data Source	<i>AAMC Data Book</i> , Association of American Medical Colleges.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	4.6 (1996–97).
Numerator	Number of degrees awarded by accredited allopathic medical schools to Hispanic or Latino persons.
Denominator	Number of degrees awarded by accredited allopathic medical schools to all persons.
Population Targeted	Students in accredited allopathic medical schools.
Questions Used To Obtain the National Data	See <i>AAMC Data Book</i> . ²

Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8i for more information.



1-8m. American Indian or Alaska Native—dentistry.

National Data Source	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
State Data Source	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	0.5 (1996–97).
Numerator	Number of degrees from accredited dental schools awarded to American Indian or Alaska Native persons.
Denominator	Number of degrees from accredited dental schools awarded to all persons.
Population Targeted	Students in accredited dental schools.
Questions Used To Obtain the National Data	<p>From the 1997–98 Survey of Predoctoral Dental Educational Institutions:</p> <p>➤ <i>How many students received a D.D.S. or D.M.D. degree between October 1, 1996 and September 30, 1997?</i> <i>(Total must equal the total number of graduates listed on the graduate class list.)</i></p>

- How many students received a D.D.S. or D.M.D. degree between October 1, 1996 and September 30, 1997 in each of the following race/ethnicity categories?

	Male	Female	Total
a. White	_____	_____	_____
b. Black	_____	_____	_____
c. Hispanic	_____	_____	_____
d. Native American	_____	_____	_____
e. Asian	_____	_____	_____
f. Not Indicated	_____	_____	_____
Total	_____	_____	_____

(Total must equal the total number of graduates listed on the graduate class list.)

Expected Periodicity

Annual.

Comments

Dental degrees include both D.D.S. and D.M.D.⁴

This objective is a modification of the Healthy People 2000 objective 21.8, which tracked the proportion of degrees awarded in all health professions (medicine, pharmacy, dentistry, and public health). This measure tracks the proportion of degrees awarded in dentistry only.

See Appendix A for focus area contact information.



1-8n. Asian or Pacific Islander—dentistry.

National Data Source

Survey of Predoctoral Dental Educational Institutions, American Dental Association.

State Data Source

Survey of Predoctoral Dental Educational Institutions, American Dental Association.

Healthy People 2000 Objective

Adapted from 21.8 (Clinical Preventive Services).

Measure

Percent.

Baseline

19.5 (1996–97).

Numerator

Number of degrees from accredited dental schools awarded to Asian or Pacific Islander persons.

Denominator

Number of degrees from accredited dental schools awarded to all persons.

Population Targeted

Students in accredited dental schools.

Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-8m.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8m for more information.



1-8o. Black or African American—dentistry.

National Data Source	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
State Data Source	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	5.1 (1996–97).
Numerator	Number of degrees from accredited dental schools awarded to black or African American persons.
Denominator	Number of degrees from accredited dental schools awarded to all persons.
Population Targeted	Students in accredited dental schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-8m.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8m for more information.



1-8p. Hispanic or Latino—dentistry.

National Data Source	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
State Data Source	Survey of Predoctoral Dental Educational Institutions, American Dental Association.

Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	4.7 (1996–97).
Numerator	Number of degrees from accredited dental schools awarded to Hispanic or Latino persons.
Denominator	Number of degrees from accredited dental schools awarded to all persons.
Population Targeted	Students in accredited dental schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 1-8m.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8m for more information.



1-8q. American Indian or Alaska Native—pharmacy.

National Data Source	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
State Data Source	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	0.4 (1996–97)
Numerator	Number of degrees awarded by accredited pharmacy schools to American Indian or Alaska Native persons.
Denominator	Number of degrees awarded by accredited pharmacy schools to all persons.
Population Targeted	Students in accredited pharmacy schools.
Questions Used To Obtain the National Data	Not applicable.

Expected Periodicity	Annual.
Comments	<p>Pharmacy degrees include both doctor of pharmacy degrees awarded as the first professional degree and postbaccalaureate degrees.⁵</p> <p>This objective is a modification of the Healthy People 2000 objective 21.8, which tracked the proportion of degrees awarded in all health professions (medicine, pharmacy, dentistry, and public health). This measure tracks the proportion of degrees awarded in pharmacy only.</p> <p>See Appendix A for focus area contact information.</p>



1-8r. Asian or Pacific Islander—pharmacy.

National Data Source	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
State Data Source	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	17.5 (1996–97).
Numerator	Number of degrees awarded by accredited pharmacy schools to Asian or Pacific Islander persons.
Denominator	Number of degrees awarded by accredited pharmacy schools to all persons.
Population Targeted	Students in accredited pharmacy schools.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8q for more information.



1-8s. Black or African American—pharmacy.

National Data Source	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
State Data Source	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	5.7 (1996–97).
Numerator	Number of degrees awarded by accredited pharmacy schools to black or African American.
Denominator	Number of degrees awarded by accredited pharmacy schools to all persons.
Population Targeted	Students in accredited pharmacy schools.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8q for more information.

**1-8t. Hispanic or Latino—pharmacy.**

National Data Source	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
State Data Source	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
Healthy People 2000 Objective	Adapted from 21.8 (Clinical Preventive Services).
Measure	Percent.
Baseline	2.8 (1996–97).
Numerator	Number of degrees awarded by accredited pharmacy schools to Hispanic or Latino persons.
Denominator	Number of degrees awarded by accredited pharmacy schools to all persons.

Population Targeted	Students in accredited pharmacy schools.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-8q for more information.



1-9. Reduce hospitalization rates for three ambulatory-care-sensitive conditions—pediatric asthma, uncontrolled diabetes, and immunization-preventable pneumonia and influenza.

1-9a. Pediatric asthma—persons under age 18 years.

National Data Source	Healthcare Cost and Utilization Project (HCUP), AHRQ (formerly AHCPH).
State Data Source	See Comments.
Healthy People 2000 Objective	Adapted from 11.1b (Environmental Health).
Measure	Rate per 10,000 population.
Baseline	23.0 (1996) (selected States—see Comments).
Numerator	Number of hospitalizations among persons under 18 years with asthma (ICD-9-CM code 493) as the first-listed (principal) diagnosis.
Denominator	Number of persons under age 18 years.
Population Targeted	Resident persons (selected States—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

HCUP contains a hospital inpatient discharge database that includes 100 percent of hospitals and 100 percent of discharges from 19 States in 1996 and 22 States in 1997. A sample of hospitals has been drawn from this that can be used to derive estimates for the U.S. population.

Data by race and ethnicity are not available, although State-level data are available for 7 of the 22 States that participated in HCUP in 1997. AHRQ is developing a Minority National Inpatient Sample as part of HCUP that will provide national estimates of disparities in avoidable hospitalization rates by race and ethnicity.

This measure is a modification of Healthy People 2000 objective 11.1b, which tracked asthma hospitalizations among children under age 14 years, using data from the National Hospital Discharge Survey, CDC, NCHS. This measure tracks persons aged 18 years and under, using data from the Healthcare Cost and Utilization Project (HCUP), AHRQ (formerly AHCPR).

See Appendix A for focus area contact information.

**1-9b. Uncontrolled diabetes—persons aged 18 to 64 years.**

National Data Source	Healthcare Cost and Utilization Project (HCUP), AHRQ (formerly AHCPR).
State Data Source	See Comments.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 10,000 population.
Baseline	7.2 (1996) (selected States—see Comments).
Numerator	Number of hospitalizations among persons aged 18 to 64 years with uncontrolled diabetes (ICD-9-CM codes 250.02-250.03, 250.10-250.13, 250.20-250.23, 250.30-250.33) as the first-listed (principal) diagnosis.
Denominator	Number of persons aged 18 to 64 years.

Population Targeted	Resident persons (selected States—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-9a for more information.



1-9c. Immunization-preventable pneumonia or influenza—persons aged 65 years and older.

National Data Source	Healthcare Cost and Utilization Project (HCUP), AHRQ (formerly AHCPH).
State Data Source	See Comments.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 10,000 population.
Baseline	10.6 (1996) (selected States—see Comments).
Numerator	Number of hospitalizations among persons aged 65 years and older with preventable pneumonia or influenza (ICD-9-CM codes 481, 487) as the first-listed (principal) diagnosis.
Denominator	Number of persons aged 65 years and older.
Population Targeted	Resident persons (selected States—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 1-9a for more information.



Emergency Services

1-10. (Developmental) Reduce the proportion of persons who delay or have difficulty in getting emergency medical care.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed numerator is the number of persons who report that they delayed or had difficulty getting emergency medical care because of any one of several possible barriers, including unsure if emergency medical care needed; needed to contact health care provider or health plan; could not take time off from work; needed child care; did not have transportation; ambulance did not arrive quickly; no health insurance; health plan requires co-payment; health plan requires pre-authorization; concerned that health plan would not pay for emergency visit; referred out of the emergency room without treatment; long wait in the emergency room/ or emergency medical facility; or an other specified reason.

The proposed denominator is the number of adults in the survey population aged 18 years and older weighted to the U.S. civilian, noninstitutionalized population.

The proposed questions to be used to obtain the data are scheduled to be included in the 2001 NHIS.

See Part C for a description of NHIS and Appendix A for focus area contact information.



1-11. (Developmental) Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the Annual Survey of EMS Operations, International Association of Firefighters.

See Appendix A for focus area contact information.



1-12. Establish a single toll-free telephone number for access to poison control centers on a 24-hour basis throughout the United States.

National Data Source	American Association of Poison Control Centers Survey, U.S. Poison Centers.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	15 (1999).
Numerator	Number of Poison Control Centers (PCCs) that report the same single toll-free telephone number for immediate information and treatment advice about poisonings and toxic exposures.
Denominator	Number of PCCs nationwide.
Questions Used To Obtain the National Data	<p>From the 1999 American Association of Poison Control Centers Survey:</p> <p>➤ <i>What emergency telephone numbers do you advertise?</i></p>
Expected Periodicity	Annual.
Comments	<p>The numerator is based on the number of PCCs that report the same toll-free telephone number that is advertised to provide immediate information and treatment advice about poisonings and toxic exposures.</p> <p>For the denominator, the total number of PCCs nationwide for 1999 is 74.</p> <p>See Appendix A for focus area contact information.</p>



1-13. Increase the number of Tribes, States, and the District of Columbia with trauma care systems that maximize survival and functional outcomes of trauma patients and help prevent injuries from occurring.

National Data Source	State EMS Directors Survey, National Association of State EMS Directors.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	5 (1998).
Numerator	Number of States and the District of Columbia that satisfied all eight trauma care system criteria.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1998 National Association of State EMS Directors Survey of EMS directors:</p> <ul style="list-style-type: none"> ➤ <i>Does someone in your State have legal authority to “designate, certify, identify, or categorize” trauma centers?</i> ➤ <i>Is there a formal process to designate or otherwise identify trauma centers?</i> ➤ <i>What standards are used for designating/identifying trauma centers?</i> ➤ <i>As part of the designation process, are the trauma centers surveyed through on-site evaluations for the purpose of verifying compliance with standards?</i> ➤ <i>Is there authority to limit the number of trauma centers based on need?</i> ➤ <i>Are there written prehospital triage protocols/criteria to transport seriously injured patients directly to a trauma center, bypassing other facilities that are not trauma centers?</i> ➤ <i>Is there a process for monitoring trauma center performance?</i> ➤ <i>Does your State’s system of trauma care consist of a single statewide trauma system?</i>
Expected Periodicity	Annual.

Comments

The eight criteria for State trauma care systems used in the National Association of State EMS Directors Survey of EMS directors in all 50 States and the District of Columbia are legal authority exists to designate, certify, identify, or categorize trauma centers; a formal process exists to designate or otherwise identify trauma centers; the American College of Surgeons (ACS) standards are used to designate or identify trauma centers; trauma center compliance with the ACS standards is verified through on-site evaluations; legal authority exists to limit the number of trauma centers based on the need for trauma services; existence of prehospital triage protocols for trauma patients, allowing providers to bypass nontrauma center hospitals and transport seriously injured patients directly to a trauma center; a process for monitoring trauma center performance exists; and trauma system coverage extends to the entire geographic area of the State.

Data for Tribes are developmental. The proposed data source is the Indian Health Service.

See Appendix A for focus area contact information.



1-14. Increase the number of States and the District of Columbia that have implemented guidelines for prehospital and hospital pediatric care.

1-14a. Increase the number of States and the District of Columbia that have implemented statewide pediatric protocols for online medical direction.

National Data Source Emergency Medical Services for Children Annual Grantees Survey, HRSA.

State Data Source Emergency Medical Services for Children Annual Grantees Survey, HRSA.

Healthy People 2000 Objective Not applicable.

Measure Number of States and the District of Columbia.

Baseline 18 (1997).

Numerator	Number of States that have pediatric protocols for both online medical direction of emergency medical technicians (EMTs) and paramedics at the scene of an emergency and overall medical direction in the development of written pediatric protocols, medical policies, and guidelines.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1997 Emergency Medical Services for Children Annual Grantees Survey:</p> <ul style="list-style-type: none"> ➤ <i>Does your State have a designated pediatric health professional involved in the development of guidelines, protocols, procedures, and policies, as well as planning for training in and evaluation of their use?</i> ➤ <i>Does your State provide for online medical direction by a professional trained in the unique emergency medical services needs of children?</i>
Expected Periodicity	Annual.
Comments	<p>This measure tracks the level of overall medical direction provided to States by physicians trained in the special needs of children when developing guidelines, protocols, procedures, and policies, as well as planning the training for and participating in the evaluation of their use.</p> <p>This measure also tracks the number of States that have EMS medical directors available to communicate directly with EMTs at the scene and during transport. Both overall medical direction and online direction must be available to respond "yes" to this measure.</p> <p>Online medical direction involves direct communication (for example, voice) between EMS medical directors and EMTs and paramedics to authorize and guide the care of patients during transport.</p> <p>The Emergency Medical Services for Children Annual Grantees Survey surveys a grantee from each of the 50 States, the District of Columbia, and 6 U.S. Territories.</p> <p>See Appendix A for focus area contact information.</p>



1-14b. Increase the number of States and the District of Columbia that have adopted and disseminated pediatric guidelines that categorize acute care facilities with the equipment, drugs, trained personnel, and other resources necessary to provide varying levels of pediatric emergency and critical care.

National Data Source	Emergency Medical Services for Children Annual Grantees Survey, HRSA.
State Data Source	Emergency Medical Services for Children Annual Grantees Survey, HRSA.
Healthy People 2000 Objective	Not applicable.
Measure	Number of States and the District of Columbia.
Baseline	11 (1997).
Numerator	Number of States and the District of Columbia that have adopted and disseminated pediatric guidelines that categorize acute care facilities with the equipment, drugs, trained personnel, and resources necessary to provide varying levels of pediatric emergency and critical care.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1997 Emergency Medical Services for Children Annual Grantees Survey:</p> <p>➤ <i>Does your State have pediatric guidelines that categorize acute care facilities with the equipment, drugs, trained personnel, and resources necessary to provide varying levels of pediatric emergency and critical care?</i></p>
Expected Periodicity	Annual.
Comments	<p>This measure tracks the number of States with either a mandatory or voluntary system with written guidelines and procedures for identifying acute care facilities with the appropriate equipment, drugs, trained personnel, and resources necessary to provide varying levels of pediatric emergency care.</p> <p>The Emergency Medical Services for Children Annual Grantees Survey surveys a grantee from each of the 50 States, the District of Columbia, and 6 U.S. Territories.</p> <p>See Appendix A for focus area contact information.</p>

Long-Term Care and Rehabilitative Services

1-15. (Developmental) Increase the proportion of persons with long-term care needs who have access to the continuum of long-term care services.

Comments

An operational definition could not be supplied at the time of publication.

Proposed national data sources are the National Long-Term Care Survey, Medicare Current Beneficiary Survey, HCFA; National Health Interview Survey (NHIS), CDC, NCHS; or the Medical Expenditure Panel Survey (MEPS), AHRQ (formerly AHCPH).

A continuum of care includes nursing home care, home health care, adult day care, assisted living, and hospice care.

Long-term care needs are defined as needing the help of another person with personal care such as eating, bathing, dressing, and getting around in the home or needing the help of other persons with routine needs such as everyday chores, doing necessary business, shopping, or getting around for other purposes are also included. Persons without access to the continuum of long-term care services are those with long-term care needs who report needing long-term care services but not receiving them in the past 12 months.

See Appendix A for focus area contact information.



1-16. Reduce the proportion of nursing home residents with a current diagnosis of pressure ulcers.

National Data Source	National Nursing Home Survey (NNHS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population.

Baseline	16 (1997).
Numerator	Number of nursing home residents reported to have a current diagnosis of a stage II or greater pressure ulcer (ICD-9-CM codes 707.0-707.1 or 454.0).
Denominator	Number of nursing home residents.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	From the 1997 National Nursing Home Survey:

- *According to (nursing home resident's name) medical record, what were (nursing home resident's name) the primary and other diagnoses at the time of admission on (patient's date of admission)?*

Primary diagnosis: 1 _____
Others: 2 _____
3 _____
4 _____
5 _____
6 _____

- *According to (nursing home resident's name) medical record, what are (nursing home resident's name) current primary and other diagnoses?*

Same as above ☐

(If not the same:)

Primary diagnosis: 1 _____
Others: 2 _____
3 _____
4 _____
5 _____
6 _____

Expected Periodicity Biennial.

Comments This measure includes any mention of a stage II or greater pressure ulcer, as either the "Primary" or "Other" diagnosis.

Tracking the rate of new cases is the most appropriate way to measure problems with pressure ulcers, however, such data are not currently available at the national level. The current NNHS measure tracks the total number of cases at the time of interview.

See Appendix A for focus area contact information.



References

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2

Arthritis, Osteoporosis, and Chronic Back Conditions

Arthritis and Other Rheumatic Conditions

- 2-1 Mean number of days without severe pain
- 2-2 Activity limitations due to arthritis
- 2-3 Personal care limitations
- 2-4 Help in coping
- 2-5 Employment rate
- 2-6 Racial differences in total knee replacement
- 2-7 Seeing a health care provider
- 2-8 Arthritis education

Osteoporosis

- 2-9 Cases of osteoporosis
- 2-10 Hospitalization for vertebral fractures

Chronic Back Conditions

- 2-11 Activity limitations due to chronic back conditions

Arthritis and Other Rheumatic Conditions

2-1. (Developmental) Increase the mean number of days without severe pain among adults who have chronic joint symptoms.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS. A proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.</p> <p>See Part C for a description of NHIS and BFRSS and Appendix A for focus area contact information.</p>
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2-2. Reduce the proportion of adults with chronic joint symptoms who experience a limitation in activity due to arthritis.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	27 (1997).
Numerator	Number of adults aged 18 years and older with chronic joint symptoms who report difficulty with activities due to arthritis/rheumatism.
Denominator	Number of adults aged 18 years and older with chronic joint symptoms.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997 National Health Interview Survey:

- *By yourself, and without using any special equipment, how difficult is it for you to...*

Walk 1/4 of a mile—about 3 city blocks?

Walk up 10 steps without resting?

Stand or be on your feet for about 2 hours?

Sit for about 2 hours?

Stoop, bend, or kneel?

Reach up over your head?

Use your fingers to grasp or handle small objects?

Lift or carry something as heavy as 10 pounds such as a full bag of groceries?

Push or pull large objects like a living room chair?

Go out to things like shopping, movies, or sporting events?

Participate in social activities such as visiting friends, attending clubs and meetings, going to parties?

Do things to relax at home or for leisure (reading, watching TV, sewing, listening to music)?

[Response categories:]

0 *Not at all difficult*

1 *Only a little difficult*

2 *Somewhat difficult*

3 *Very difficult*

4 *Can't do at all*

[If response categories are 1-4 to any of the above statements:]

- *What condition or health problem causes you to have difficulty with {names of up to 3 specified activities/these activities}?*

[Response categories include:]

Arthritis/rheumatism

- *During the PAST 12 MONTHS, have you had pain, aching, stiffness or swelling in or around a joint?*

[If yes:]

- *Were these symptoms present on MOST DAYS FOR AT LEAST ONE MONTH?*

Expected Periodicity Annual.

Comments

Persons are considered to have chronic joint symptoms (arthritis) if they report having had pain, aching, stiffness, or swelling in or around a joint for most days for at least 1 month in the past 12 months. Persons were considered to be limited in activity if they reported that it was only a little difficult, somewhat difficult, very difficult, or they could not do at all any of the activities listed above. The limitation was considered to be due to arthritis if they selected "arthritis/rheumatism" from the list of conditions.

The NHIS, with input from the National Arthritis Data Workgroup, changed its approach to collecting arthritis data in 1996. Instead of asking for self reports of arthritis diagnosis, which is difficult for many respondents who do not know their type of arthritis, the NHIS now asks for self-reports of symptoms.

A proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS). The personal interview-based NHIS and the telephone-based BRFSS optional arthritis module ask identical questions about pain, aching, stiffness, or swelling in or around a joint that was present on most days for at least 1 month in the past 12 months (the self-report definition of chronic joint symptoms).

The new field of arthritis public health is evolving rapidly and case definitions may change as understanding improves. Cognitive testing and validation of self-reports and other arthritis-related questions over the next few years may result in the rephrasing of some of the national arthritis objectives.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and Appendix A for focus area contact information.



2-3. Reduce the proportion of all adults with chronic joint symptoms who have difficulty in performing two or more personal care activities, thereby preserving independence.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).

Baseline	2.0 (1997).
Numerator	Number of adults aged 18 years and older with chronic joint symptoms who report difficulty with two or more personal care activities.
Denominator	Number of adults aged 18 years and older with chronic joint symptoms.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Health Interview Survey:</p> <ul style="list-style-type: none"> ➤ <i>Because of a physical, mental, or emotional problem, (do/does) (Person) need the help of other persons with PERSONAL CARE NEEDS, such as eating, bathing, dressing, or getting around inside this home?</i> <p>[If yes:]</p> <ul style="list-style-type: none"> ○ <i>(Do/Does) (Person) need the help of other persons with...</i> <ul style="list-style-type: none"> <i>bathing or showering?</i> <i>dressing?</i> <i>eating?</i> <i>getting in or out of bed or chairs?</i> <i>using the toilet, including getting to the toilet?</i> <i>getting around inside the home?</i> ➤ <i>During the PAST 12 MONTHS, have you had pain, aching, stiffness or swelling in or around a joint?</i> <p>[If yes:]</p> <ul style="list-style-type: none"> ○ <i>Were these symptoms present on MOST DAYS FOR AT LEAST ONE MONTH?</i>
Expected Periodicity	Annual.
Comments	<p>Persons are considered to have chronic joint symptoms (arthritis) if they report having had pain, aching, stiffness, or swelling in or around a joint for most days for at least one month in the past 12 months. Persons are considered to have difficulty with personal care activities if they responded "yes" to needing help of other persons with two or more of the six personal care activities listed above.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p> <p>See Comments provided with objective 2-2 for more information.</p>

See Part C for a description of NHIS and Appendix A for focus area contact information.



2-4. (Developmental) Increase the proportion of adults aged 18 years and older with arthritis who seek help in coping if they experience personal and emotional problems.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS. A proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.</p> <p>See Part C for a description of NHIS and BFRSS and Appendix A for focus area contact information.</p>
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2-5. Increase the employment rate among adults with arthritis in the working-aged population.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	67 (1997).
Numerator	Number of adults aged 18 to 64 years with chronic joint symptoms who report being employed.
Denominator	Number of adults aged 18 to 64 years who report having chronic joint symptoms.
Population Targeted	U.S. civilian, noninstitutionalized population
Questions Used To Obtain the National Data	From the 1997 National Health Interview Survey:

[NUMERATOR:]

- Which of the following {were/was} {person} doing last week?
 - Working at a job or business
 - With a job or business but not at work
 - Looking for work
 - Not working at a job or business

[DENOMINATOR:]

- During the PAST 12 MONTHS, have you had pain, aching, stiffness or swelling in or around a joint?
 - [If yes:]
 - Were these symptoms present on MOST DAYS FOR AT LEAST ONE MONTH?

Expected Periodicity

Annual.

Comments

Persons are considered employed if they answered “yes” to “working at a job or business” or “with a job or business but not at work.” Persons are considered to have chronic joint symptoms (arthritis) if they report having had pain, aching, stiffness, or swelling in or around a joint for most days for at least 1 month in the past 12 months.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Comments provided with objective 2-2 for more information.

See Part C for a description of NHIS and Appendix A for focus area contact information.



2-6. (Developmental) Eliminate racial disparities in the rate of total knee replacements.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are Medicare records, HCFA, National Hospital Discharge Survey (NHDS), CDC, NCHS; and Hospital Cost and Utilization Project (HCUP), AHQR.

See Appendix A for focus area contact information.

2-7. (Developmental) Increase the proportion of adults who have seen a health care provider for their chronic joint symptoms.

Comments An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS. A proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

See Appendix A for focus area contact information.



2-8. (Developmental) Increase the proportion of persons with arthritis who have had effective, evidence-based arthritis education as an integral part of the management of their condition.

Comments An operational definition could not be specified at the time of publication.

Effective, evidence-based arthritis education includes information about community and self-help resources.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS. A proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

See Appendix A for focus area contact information.



Osteoporosis

2-9. Reduce the proportion of adults with osteoporosis.

National Data Source National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

State Data Source Not identified.

Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	10 (1988–94).
Numerator	Number of adults aged 50 years and older with a femoral bone mineral density (BMD) value less than 0.64.
Denominator	Number of adults aged 50 years and older.
Population Targeted	U.S. civilian, non-institutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999.
Comments	<p>Bone mineral densities are determined from measurements made as part of the NHANES battery of examinations. The choice of a femoral BMD of less than 0.64 is the measure 2.5 or more standard deviations below the reference mean for young adults aged 20 to 29 years.^{1, 2}</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NHANES and Appendix A for focus area contact information.</p>



2-10. Reduce the proportion of adults who are hospitalized for vertebral fractures associated with osteoporosis.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge data systems.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 10,000 population (age adjusted—see Comments).
Baseline	17.5 (1998).

Numerator	Number of discharges from short-stay hospitals among persons aged 65 years and older for vertebral fractures (ICD-9-CM codes 805.0, 805.2, 805.4, or 805.8 in any listed diagnostic field).
Denominator	Number of persons aged 65 years and older.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	From the 1998 National Hospital Discharge Survey: <ul style="list-style-type: none"> ➤ <i>Final diagnoses:</i> <ul style="list-style-type: none"> ○ <i>Principal:</i> ○ <i>Other/additional:</i>
Expected Periodicity	Annual.
Comments	<p>Discharges with an ICD code indicating vertebral fracture due to osteoporosis included any person with a diagnosis of closed cervical, thoracic, or lumbar spine fracture without spinal cord involvement (ICD-9-CM codes 805.0, 805.2, or 805.4) in any of the seven diagnostic fields. Closed spinal injuries elusive of cord involvement without reference to a specific site (ICD-9-CM code 805.8) were also included. These criteria selected the vertebral fractures most likely to be due to osteoporosis by excluding open vertebral fractures and those with spinal cord involvement, which are usually due to severe trauma.³</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NHDS and Appendix A for focus area contact information.</p>



Chronic Back Conditions

2-11. Reduce activity limitation due to chronic back conditions.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population (age adjusted—see Comments).
Baseline	32 (1997).
Numerator	Number of adults aged 18 years and older with limitation in activity due to chronic back or neck problems.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Health Interview Survey:</p> <ul style="list-style-type: none">➤ <i>Because of a physical, mental, or emotional problem, (do/does) (Person) need the help of other persons with PERSONAL CARE NEEDS, such as eating, bathing, dressing, or getting around inside this home?</i> [If yes:]<ul style="list-style-type: none">○ <i>(Do/Does) (Person) need the help of other persons with...</i> <i>bathing or showering?</i> <i>dressing?</i> <i>eating?</i> <i>getting in or out of bed or chairs?</i> <i>using the toilet, including getting to the toilet?</i> <i>getting around inside the home?</i>➤ <i>Because of a physical, mental, or emotional problem, (do/does) (Person) need the help of other persons in handling ROUTINE NEEDS, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?</i>➤ <i>Does a physical, mental, or emotional problem keep (Person 18+) from working at a job or business?</i>

- *(Are/(Other than the persons mentioned are) any of these family members) (Person 18+) limited in the kind OR amount of work (you/they) can do because of a physical, mental or emotional problem?*
- *Because of a health problem, (do/does) (you/anyone) in the family walking without using any special equipment?*
- *(Are/Is) (you/anyone) in the family LIMITED IN ANY WAY in any activities because of difficulty remembering or because {you/they} experience periods of confusion?*
- *What conditions or health problems cause (Person) limitations?*

[Response categories include:]
Back or neck problem causes limitation
- *How long (have/has) (Person) had this back or neck problem?*

Expected Periodicity

Periodic.

Comments

The estimate for chronic back conditions includes neck problems because of the way the questionnaire was worded. The condition is considered “chronic” if it has lasted 3 months or more. Persons are considered limited in activity if they respond “yes” to any of the activity limitation questions listed above: personal care needs; routine needs; or physical, mental, or emotional problems that preclude working or limit the kind or amount of work that can be done.

Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and Appendix A for focus area contact information.



References

1. World Health Organization (WHO). *Assessment of Fracture Risk and Its Application to Screening for Postmenopausal Osteoporosis*. Technical Report Series No. 843. Geneva, Switzerland: WHO, 1994.
2. Looker, A.C.; Orwoll, E.S.; Johnston, C.C.; et al. Prevalence and low femoral bone density in older U.S. adults from NHANES III. *Journal of Bone and Mineral Research* 12:1761-8, 1997.
3. Jacobsen, S.J.; Cooper, C.; Gottlieb, M.S.; et al. Hospitalization with vertebral fracture among the aged: A national population-based study, 1986–1989. *Epidemiology* 3(6):515-518, 1992.

3

Cancer

- 3-1 Overall cancer deaths
- 3-2 Lung cancer deaths
- 3-3 Breast cancer deaths
- 3-4 Cervical cancer deaths
- 3-5 Colorectal cancer deaths
- 3-6 Oropharyngeal cancer deaths
- 3-7 Prostate cancer deaths
- 3-8 Melanoma deaths
- 3-9 Sun exposure and skin cancer
 - 3-9a Adolescents in grades 9-12
 - 3-9b Adults aged 18 years and older
- 3-10 Provider counseling about cancer prevention
 - 3-10a Internists—smoking cessation
 - 3-10b Family physicians—smoking cessation
 - 3-10c Dentists—smoking cessation
 - 3-10d Primary care providers—blood stool tests
 - 3-10e Primary care providers—proctoscopic examinations
 - 3-10f Primary care providers—mammograms
 - 3-10g Primary care providers—Pap tests
 - 3-10h Primary care providers—physical activity
- 3-11 Pap tests
 - 3-11a Ever received a Pap test
 - 3-11b Received a Pap test within the preceding 3 years
- 3-12 Colorectal cancer screening
 - 3-12a Fecal occult blood test
 - 3-12b Sigmoidoscopy
- 3-13 Mammograms
- 3-14 Statewide cancer registries
- 3-15 Cancer survival

3-1. Reduce the overall cancer death rate.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	16.1 (Cancer) (also 2.2), age adjusted to the 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	202.4 (1998).
Numerator	Number of deaths due to cancer (ICD-9 codes 140-208).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 16.1, which age adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



3-2. Reduce the lung cancer death rate.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.

Healthy People 2000 Objective	Adapted from 16.2 (Cancer) (also 3.2).
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	57.6 (1998).
Numerator	Number of deaths due to lung cancer (ICD-9 code 162).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>This objective is measured with slightly different ICD-9 codes from those used to measure the comparable Healthy People 2000 objective 16.2 (ICD-9 code 162 vs. 162.2-162.9). Additionally, the Healthy People 2000 objective age adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



3-3. Reduce the breast cancer death rate.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	16.3 (Cancer), age adjusted to the 2000 standard population.
Measure	Rate per 100,000 female population (age adjusted—see Comments).

Baseline	27.9 (1998).
Numerator	Number of female deaths due to breast cancer (ICD-9 code 174).
Denominator	Number of females.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 16.3, which age adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



3-4. Reduce the death rate from cancer of the uterine cervix.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	16.4 (Cancer), age adjusted to the 2000 standard population.
Measure	Rate per 100,000 female population (age adjusted—see Comments).
Baseline	3.0 (1998).
Numerator	Number of female deaths due to cancer of the uterine cervix (ICD-9 code 180).
Denominator	Number of females.
Population Targeted	U.S. resident population.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 16.4, which age adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



3-5. Reduce the colorectal cancer death rate.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Adapted from 16.5 (Cancer) (also 2.23).
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	21.2 (1998).
Numerator	Number of deaths due to colorectal cancer (ICD-9 codes 153, 154).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>This objective is measured with slightly different ICD-9 codes from those used to measure the comparable Healthy People 2000 objective 16.5 (ICD-9 codes 153.0-154.3, 154.8, 159.0). Additionally, the Healthy People 2000 objective age adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>
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3-6. Reduce the oropharyngeal cancer death rate.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Adapted from 13.7 (Oral Health) (also 3.17 and 16.17).
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	3.0 (1998).
Numerator	Number of deaths due to oropharyngeal cancer (ICD-9 codes 140-149).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.

This objective differs from Healthy People 2000 objective 16.17, which age adjusted the death rates using the 1940 standard population. Additionally, the Healthy People 2010 objective targets the total population while the Healthy People 2000 objective targeted only persons 45 to 74 years. See Appendix C for comparison data.

See Part C for a description of NVSS and Appendix A for focus area contact information.



3-7. Reduce the prostate cancer death rate.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 male population (age adjusted—see Comments).
Baseline	32.0 (1998).
Numerator	Number of male deaths due to prostate cancer (ICD-9 code 185).
Denominator	Number of males.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



3-8. Reduce the rate of melanoma cancer deaths.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	2.8 (1998).
Numerator	Number of deaths due to melanoma cancer (ICD-9 code 172).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



3-9. Increase the proportion of persons who use at least one of the following protective measures that may reduce the risk of skin cancer: avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing when exposed to sunlight, use sunscreen with a sun protective factor (SPF) of 15 or higher, and avoid artificial sources of ultraviolet light.

3-9a. (Developmental) Increase the proportion of adolescents in grades 9 through 12 who follow protective measures that may reduce the risk of skin cancer.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>The Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP, is a proposed data source for this objective.</p> <p>See Appendix A for focus area contact information.</p>
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3-9b. Increase the proportion of adults aged 18 years and older who follow protective measures that may reduce the risk of skin cancer.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 16.9 (Cancer).
Measure	Percent (age adjusted—see Comments).
Baseline	47 (1998).
Numerator	Number of adults aged 18 years and older who report that they are very likely to limit sun exposure, use sunscreen, or wear protective clothing.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <ul style="list-style-type: none"> ➤ <i>If you were to go outside on a very sunny day for MORE than one hour, are you very likely, somewhat likely, or unlikely to wear protective clothing such as wide brimmed hats or long sleeved shirts?</i> ➤ <i>If you were to go outside on a very sunny day for MORE than one hour, are you very likely, somewhat likely, or unlikely to avoid the sun by staying in the shade?</i> ➤ <i>If you were to go outside on a very sunny day for MORE than one hour, are you very likely, somewhat likely, or unlikely to use sunscreen or sun block lotion?</i>
Expected Periodicity	Annual.

Comments

For this objective, a person is defined as following protective measures if the person answers “very likely” to one or more of the questions listed above.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

Although similar questions are used to measure this objective and the comparable Healthy People 2000 objective 16.9, the data for the Healthy People 2010 objective are age adjusted while data for the Healthy People 2000 objective are unadjusted rates.

Additionally, the Healthy People 2010 objective combines the data from the three questions into one measure while the Healthy People 2000 objective considered them individually.

See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



3-10. Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening.

3-10a. Internists who counsel about smoking cessation.

Comments

A complete operational definition was not specified at the time of publication.

This objective is adapted from Healthy People 2000 objectives 16.10 and 3.16.

See Appendix A for focus area contact information.



3-10b. Family physicians who counsel about smoking cessation.

Comments

A complete operational definition was not specified at the time of publication.

This objective is adapted from Healthy People 2000 objectives 16.10 and 3.16.

See Appendix A for focus area contact information.



3-10c. Dentists who counsel about smoking cessation.

Comments

A complete operational definition was not specified at the time of publication.

This objective is adapted from Healthy People 2000 objectives 16.10 and 3.16.

See Appendix A for focus area contact information.



3-10d. Primary care providers who counsel about blood stool tests.

Comments

A complete operational definition was not specified at the time of publication.

This objective is adapted from Healthy People 2000 objective 16.10.

See Appendix A for focus area contact information.



3-10e. Primary care providers who counsel about proctoscopic examinations.

Comments

A complete operational definition was not specified at the time of publication.

This objective is adapted from Healthy People 2000 objective 16.10.

See Appendix A for focus area contact information.



3-10f. Primary care providers who counsel about mammograms.

Comments

A complete operational definition was not specified at the time of publication.

This objective is adapted from Healthy People 2000 objective 16.10.

See Appendix A for focus area contact information.



3-10g. Primary care providers who counsel about Pap tests.

Comments

A complete operational definition was not specified at the time of publication.

This objective is adapted from Healthy People 2000 objective 16.10.

See Appendix A for focus area contact information.



3-10h. Primary care providers who counsel about physical activity.

Comments

A complete operational definition was not specified at the time of publication.

This objective is adapted from Healthy People 2000 objective 16.10.

See Appendix A for focus area contact information.



3-11. Increase the proportion of women who receive a Pap test.

3-11a. Women aged 18 years and older who have ever received a Pap test.

National Data Source National Health Interview Survey (NHIS), CDC, NCHS.

State Data Source Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

Healthy People 2000 Objective 16.12 (Cancer), age adjusted to the 2000 standard population.

Measure Percent (age adjusted—see Comments).

Baseline 92 (1998).

Numerator	Number of women aged 18 years and older who report ever receiving a Pap test.
Denominator	Number of women aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey: ➤ <i>Have you ever had a pap smear test?</i>
Expected Periodicity	Periodic.
Comments	Data include women without a uterine cervix. Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5. See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



3-11b. Women aged 18 years and older who received a Pap test within the preceding 3 years.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	16.12 (Cancer), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	79 (1998).
Numerator	Number of women aged 18 years and older who report receiving a Pap test within the past 3 years.
Denominator	Number of women aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey:

➤ *Have you ever had a pap smear test?*

[If yes:]

- *When did you have your most recent pap smear test? Was it a year ago or less, more than 1 year but not more than two years, more than two years but not more than three years, more than three years but not more than five years, or over 5 years ago?*

Expected Periodicity Periodic.

Comments Data include women without a uterine cervix.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



3-12. Increase the proportion of adults who receive a colorectal cancer screening examination.

3-12a. Adults aged 50 years and older who have received a fecal occult blood test (FOBT) within the preceding 2 years.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	16.13 (Cancer), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	35 (1998).
Numerator	Number of adults aged 50 years and older who report receiving fecal occult blood testing within the preceding 2 years.
Denominator	Number of adults aged 50 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data

From the 1998 National Health Interview Survey:

- *A blood stool test is when the stool is examined to determine whether it contains blood. Have you ever had a blood stool test?*

[If yes:]

- *When did you have your most recent blood stool test? Was it a year ago or less, more than 1 but not more than 2 years, more than 2 years but not more than 3 years, more than 3 years but not more than 5 years, or more than 5 years ago?*

Expected Periodicity

Periodic.

Comments

A fecal occult blood test (FOBT) is referred to as a blood stool tests in the NHIS.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



3-12b. Adults aged 50 years and older who have ever received a sigmoidoscopy.

National Data Source

National Health Interview Survey (NHIS), CDC, NCHS.

State Data Source

Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

Healthy People 2000 Objective

16.13 (Cancer), age adjusted to the 2000 standard population.

Measure

Percent (age adjusted—see Comments).

Baseline

37 (1998).

Numerator

Number of adults aged 50 years and older who report ever receiving a sigmoidoscopy.

Denominator

Number of adults aged 50 years and older.

Population Targeted

U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>➤ <i>A proctoscopic examination is when a tube is inserted in the rectum to check for problems. Have you ever had a proctoscopic examination?</i></p>
Expected Periodicity	Periodic.
Comments	<p>A sigmoidoscopy is referred to as a proctoscopic examination in NHIS.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.</p>



3-13. Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 16.11 (Cancer).
Measure	Percent (age adjusted—see Comments).
Baseline	67 (1998).
Numerator	Number of women aged 40 years and older who report receiving a mammogram within the past 2 years.
Denominator	Number of women aged 40 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey:

- *A mammogram is an x-ray taken only of the breasts by a machine that presses the breast against a plate. Have you ever had a mammogram?*

[If yes:]

- *When did you have your most recent mammogram? Was it a year ago or less, more than 1 year but not more than 2 years, more than 2 years but not more than 3 years, more than 3 years but not more than 5 years, or over 5 years ago?*

Expected Periodicity Periodic.

Comments Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

Although similar questions are used to measure this objective and the comparable Healthy People 2000 objective 16.11, the Healthy People 2010 focuses solely on mammograms received by women 40 years and older while the Healthy People 2000 objective measured women 50 years and older who received both mammograms and clinical breast examinations by. Additionally, the data for the Healthy People 2010 objective are age adjusted while data for the Healthy People 2000 objective are unadjusted rates.

See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



3-14. Increase the number of States that have a statewide population-based cancer registry that captures case information on at least 95 percent of the expected number of reportable cancers.

National Data Source	National Program of Cancer Registries (NPCR), CDC, NCI.
State Data Source	National Program of Cancer Registries (NPCR), CDC, NCI.
Healthy People 2000 Objective	Not applicable.
Measure	Number of States and the District of Columbia.

Baseline	21 (1999) (selected areas—see Comments).
Numerator	Number of States not covered by the SEER program that capture information on at least 95 percent of the expected number of malignant cases occurring in State residents each diagnosis year.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>For the purpose of reporting to state registries, a diagnosis year is the date of initial diagnosis by a recognized medical practitioner for the tumor being reported.</p> <p>The NPCR provides funds to 45 States, 3 territories, and the District of Columbia to assist in planning or enhancing cancer registries; develop model legislation and regulations for programs to increase the viability of registry operations; set standards for data quality, completeness, and timeliness; provide training for registry personnel; and help establish computerized reporting and data processing systems. The Surveillance, Epidemiology, and End Results Program (SEER) covers the remaining five States.</p> <p>NPCR supported registries are expected to meet CDC data standards, as well as incorporate standards for data quality and format as described by the North American Association of Cancer Registries. Additional information on the standards for completeness, accuracy, and timeliness of central registry reporting, can be found at the following Web site: http://www.cdc.gov/cancer/.</p> <p>See Appendix A for focus area contact information.</p>



3-15. Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis.

National Data Source	Surveillance, Epidemiology, and End Results Program (SEER), NIH, NCI.
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State Data Source	Surveillance, Epidemiology, and End Results Program (SEER), NIH, NCI.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	59 (1989–95) (selected areas—see Comments).
Numerator	5-year observed survival rate.
Denominator	5-year expected survival rate.
Population Targeted	Resident cancer survivors (selected areas—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>This measure is tracked with a calculation commonly referred to as the relative survival rate.</p> <p>The relative survival rate is calculated using a procedure whereby the observed survival rate is adjusted for expected mortality. The relative survival rate represents the likelihood that a patient will not die from causes associated specifically with the given cancer before some specified time (usually 5 years) after diagnosis.</p> <p>To calculate the relative survival rate, the observed survival rate is divided by the expected survival rate. The observed survival rate is based on all causes of death—no one is excluded except for those lost to followup. The expected survival rate is based on lifetables of surviving 1 year in the general population based on age (single year), race, sex, and year (1970, 1980, 1990) of the cohort of cancer patients. This calculation is used so that one does not have to depend on the accuracy and completeness of the cause of death information in order to calculate the effect of the cancer.</p>

Survival rates are from the SEER program. They are based of data from population-based registries in Connecticut, New Mexico, Utah, Iowa, Hawaii, Atlanta, GA, Detroit, Michigan, Seattle-Puget Sound, WA, and San Francisco-Oakland, CA. The 1989–95 survival rates used in the baseline are based on patient followup through 1996.

Additional information on the SEER program can be found at the following Web site:
<http://www.seer.ims.nci.nih.gov/>.

See Appendix A for focus area contact information.



4

Chronic Kidney Disease

- 4-1 End-stage renal disease
- 4-2 Cardiovascular disease deaths in persons with chronic kidney failure
- 4-3 Counseling for chronic kidney failure care
- 4-4 Use of arteriovenous fistulas
- 4-5 Registration for kidney transplantation
- 4-6 Waiting time for kidney transplantation
- 4-7 Kidney failure due to diabetes
- 4-8 Medical therapy for persons with diabetes and proteinuria

4-1. Reduce the rate of new cases of end-stage renal disease (ESRD).

National Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
State Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
Healthy People 2000 Objective	Adapted from 15.3 (Heart Disease and Stroke).
Measure	Rate per million.
Baseline	289 (1997).
Numerator	Number of ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration forms (HCFA Medical Evidence Form 2728) submitted to Medicare for renal replacement therapy in the past 12 months.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Renal replacement therapy includes renal dialysis and kidney transplants. Qualification for renal replacement therapy is based on eligibility for Medicare and the submission of the HCFA Medical Evidence Form (HCFA-2728). More information on HCFA-2728 is available from USRDS.¹</p> <p>This objective is a modification of Healthy People 2000 objective 15.3 which used incident count data on ESRD patients published in the Annual Data Report (ADR) for the numerator.¹ The U.S. resident population, published by the U.S. Census Bureau, was used as the denominator. The Healthy People 2000 measure was an unadjusted rate per 100,000 population. The Healthy People 2010 measure uses age-, race-, and sex-adjusted rates per million population published in USRDS ADR.¹ More information on the analytic methods used to calculate this measure can be found in chapter 13 of the 1999 ADR.¹</p>

The USRDS data, data collection procedures, calculation methods, and other technical information are included in its Annual Data Report.¹

USRDS uses data collected from Medicare eligible persons with ESRD. Over 96 percent of all ESRD cases are included in the Medicare eligible population. Health care providers of ESRD cases with private health insurance are not required to provide patient information to USRDS, thus these data are not included in USRDS.

See Part C for a description of USRDS and Appendix A for focus area contact information.



4-2. Reduce deaths from cardiovascular disease in persons with chronic kidney failure.

National Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
State Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 patient years at risk.
Baseline	70 (1997).
Numerator	Number of deaths among persons with chronic kidney failure (ICD-9 code 585) who also had cardiovascular disease (ICD-9 390-448).
Denominator	Number of persons with chronic kidney failure (ICD-9 code 585).
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	This measure is translated into patient years at risk (instead of a rate per population) in order to obtain a more uniform rate to track over time. Analytical methods for converting the rate into patient years at risk are provided in chapter 13 of the 1999 Annual Data Report. ¹

The USRDS data, data collection procedures, calculation methods, and other technical information are included in its Annual Data Report.¹

USRDS uses data collected from Medicare eligible persons with ESRD. Over 96 percent of all ESRD cases are included in the Medicare eligible population. Health care providers of ESRD cases with private health insurance are not required to provide patient information to USRDS, thus these data are not included in USRDS.

See Part C for a description of USRDS and Appendix A for focus area contact information.



4-3. Increase the proportion of treated chronic kidney failure patients who have received counseling on nutrition, treatment choices, and cardiovascular care 12 months before the start of renal replacement therapy.

National Data Source	USRDS Dialysis Mortality and Morbidity Study (DMMS) Wave 1, U.S. Renal Data System (USRDS), NIH, NIDDK.
State Data Source	USRDS Dialysis Mortality and Morbidity Study (DMMS) Wave 1, U.S. Renal Data System (USRDS), NIH, NIDDK.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	45 (1996).
Numerator	Number of persons with chronic kidney failure who are reported to receive counseling on nutrition, treatment choices, and cardiovascular care at least 12 months prior to starting renal replacement therapy.
Denominator	Number of persons in the study population with chronic kidney failure (ICD-9-CM code 585).
Population Targeted	U.S. resident population.

Questions Used To Obtain the National Data	For the USRDS Dialysis Mortality and Morbidity Study (DMMS) Wave 1 questions, see Data Collection Forms for USRDS Special Studies at http://www.usrds.org/research_guide.htm .
Expected Periodicity	Annual.
Comments	<p>This measure is being tracked using data from USRDS special study, Dialysis Mortality and Morbidity Study (DMMS). Additional information on USRDS Special Studies is published by USRDS.²</p> <p>The USRDS data, data collection procedures, calculation methods, and other technical information are included in its Annual Data Report.¹</p> <p>USRDS uses data collected from Medicare eligible persons with ESRD. Over 96 percent of all ESRD cases are included in the Medicare eligible population. Health care providers of ESRD cases with private health insurance are not required to provide patient information to USRDS, thus these data are not included in USRDS.</p> <p>See Part C for a description of USRDS and Appendix A for focus area contact information.</p>



4-4. Increase the proportion of new hemodialysis patients who use arteriovenous fistulas as the primary mode of vascular access.

National Data Source	USRDS Dialysis Mortality and Morbidity Study (DMMS) Wave 1, U.S. Renal Data System (USRDS), NIH, NIDDK.
State Data Source	USRDS Dialysis Mortality and Morbidity Study (DMMS) Wave 1, U.S. Renal Data System (USRDS), NIH, NIDDK.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	29 (1997).
Numerator	Number of persons who started hemodialysis in the past year who are reported to use arteriovenous (a-v) fistulas as the primary mode of vascular access.

Denominator	Number of persons in the study population who started hemodialysis in the past year.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	For the USRDS Dialysis Mortality and Morbidity Study (DMMS) Wave 1 questions, see Data Collection Forms for USRDS Special Studies at http://www.usrds.org/research_guide.htm .
Expected Periodicity	Annual.
Comments	See Comments provided with objective 4-3 for more information.



4-5. Increase the proportion of dialysis patients registered on the waiting list for transplantation.

National Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
State Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	20 (1994–96).
Numerator	Number of persons under age 70 years registered on the kidney transplant waiting list (see Comments).
Denominator	Number of persons on dialysis under age 70 years.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data on the number of persons on transplant waiting lists include data from the United Network for Organ Sharing (UNOS). A complete description of the transplantation data (including UNOS) used to track this objective is available from USRDS.²</p> <p>The USRDS data, data collection procedures, calculation methods, and other technical information are included in its Annual Data Report.¹</p>

USRDS uses data collected from Medicare eligible persons with ESRD. Over 96 percent of all ESRD cases are included in the Medicare eligible population. Health care providers of ESRD cases with private health insurance are not required to provide patient information to USRDS, thus these data are not included in USRDS.

See Part C for a description of USRDS and Appendix A for focus area contact information.



4-6. Increase the proportion of patients with treated chronic kidney failure who receive a transplant within 3 years of registration on the waiting list.

National Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
State Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 patient years at risk (since placed on dialysis).
Baseline	41 (1995–97).
Numerator	Number of patients with treated chronic kidney failure who are reported to have received a kidney transplant within 3 years from the date of registering for a donated kidney.
Denominator	Number of ESRD patients who are in treatment for chronic kidney failure and are eligible for a kidney transplant in the past 3 years.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

This measure is translated into patient years at risk (instead of a rate per population) in order to obtain a more uniform rate to track over time. Analytical methods for converting the rate into patient years at risk are provided in chapter 13 of the 1999 Annual Data Report.¹

A complete description of the transplantation data (including UNOS) used to track this objective is available from USRDS.²

The USRDS data, data collection procedures, calculation methods, and other technical information are included in its Annual Data Report.¹

USRDS uses data collected from Medicare-eligible persons with ESRD. Over 96 percent of all ESRD cases are included in the Medicare eligible population. Health care providers of ESRD cases with private health insurance are not required to provide patient information to USRDS, thus these data are not included in USRDS.

See Part C for a description of USRDS and Appendix A for focus area contact information.



4-7. Reduce kidney failure due to diabetes.

National Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
State Data Source	U.S. Renal Data System (USRDS), NIH, NIDDK.
Healthy People 2000 Objective	Adapted from 17.10 (Diabetes and Chronic Disabling Conditions).
Measure	Rate per million.
Baseline	113 (1996).
Numerator	Number of reported ESRD patients with diabetes.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

This objective is a modification of Healthy People 2000 objective 17.10, which used incident count data on ESRD patients with diabetes published in the Annual Data Report (ADR) for the numerator.¹ The number of persons who report ever being diagnosed with diabetes from the National Health Interview Survey (NHIS), CDC, NCHS, was used as the Healthy People 2000 denominator. The Healthy People 2010 measure uses age-, race-, and sex-adjusted rates per million population published in USRDS ADR. More information on the analytic methods used to calculate this measure can be found in chapter 13 of the 1999 ADR.¹

USRDS data, data collection procedures, calculation methods, and other technical information are included in its Annual Data Report.¹

USRDS uses data collected from Medicare eligible persons with ESRD. Over 96 percent of all ESRD cases are included in the Medicare eligible population. Health care providers of ESRD cases with private health insurance are not required to provide patient information to USRDS, thus these data are not included in USRDS.

See Part C for a description of USRDS and Appendix A for focus area contact information.



4-8. (Developmental) Increase the proportion of persons with type 1 or type 2 diabetes and proteinuria who receive recommended medical therapy to reduce progression to chronic renal insufficiency.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data sources are the National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS and the National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

The proposed survey questions to be used to obtain the national data are from the 1997 NAMCS/NHAMCS:

- *Physician's Diagnosis for this Visit- As specifically as possible, list diagnoses related to this visit including chronic conditions.*

1. Primary Diagnosis: _____
2. Other: _____
3. Other: _____

- *Does Patient Now Have:[Check all that apply]*

1. Depression
2. Asthma
3. Ischemic heart disease
4. Obesity
5. Hypertension
6. Diabetes
7. Arthritis
8. Hyperactivity/ADD
9. None of the above

- *MEDICATIONS & INJECTIONS - including R_x and OTC medications, immunizations, allergy shots, anesthetics, and dietary supplements.*

☐ *None - No medications/injections*

☐ *Yes - Please record below:*

- *List up to 8 drugs that were ordered, supplied, administered or continued during this visit.*

Medication/vaccine: _____

Enter dosage and route information.

Strength: _____

Route: _____

(For Route enter: O -Oral; E -Eyes; I -Inhalation; T -Topical/transdermal; IV -Intravenous; IM - Intramuscular; J -Other injection; X -Other; U - Unknown/unspecified)

Check all that apply.

☐ *Regimen*
☐ *New*
☐ *Drug*
☐ *From Formulary*
☐ *For Dx1*
☐ *For Dx2*
☐ *For Dx3*

The proposed measure will track physician visits by persons with diabetes (ICD-9-CM code of 250) and have either angiotensin receptor blocker or angiotensin converting enzyme inhibitors medications ordered, supplied, administered or continued during the visit.

See Part C for descriptions of NAMCS and NHAMCS, and Appendix A for focus area contact information.



References

1. U.S. Renal Data System (USRDS). *USRDS 1999 Annual Data Report*. Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 1999.
2. Researcher's Guide to the USRDS Database. <http://www.usrds.org/research_guide.htm>April 1999.

5

Diabetes

- 5-1 Diabetes education
- 5-2 New cases of diabetes
- 5-3 Overall cases of diagnosed diabetes
- 5-4 Diagnosis of diabetes
- 5-5 Diabetes deaths
- 5-6 Diabetes-related deaths
- 5-7 Cardiovascular disease deaths in persons with diabetes
- 5-8 Gestational diabetes
- 5-9 Foot ulcers
- 5-10 Lower extremity amputations
- 5-11 Annual urinary microalbumin measurement
- 5-12 Annual glycosylated hemoglobin measurement
- 5-13 Annual dilated eye examinations
- 5-14 Annual foot examinations
- 5-15 Annual dental examinations
- 5-16 Aspirin therapy
- 5-17 Self-blood-glucose-monitoring

5-1. Increase the proportion of persons with diabetes who receive formal diabetes education.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	17.14 (Diabetes and Chronic Disabling Conditions), age adjusted to 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	45 (1998).
Numerator	Number of persons aged 18 years and older who report that they have ever been diagnosed with diabetes and have taken a course or class in diabetes self-management.
Denominator	Number of persons aged 18 years and older who report that they have ever been diagnosed with diabetes.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>[NUMERATOR:]</p> <p>➤ <i>Have you ever taken a course or class in how to manage your diabetes yourself?</i></p> <p>[DENOMINATOR:]</p> <p>[For females:]</p> <p>➤ <i>Other than during pregnancy, have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?</i></p> <p>[For males:]</p> <p>➤ <i>Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?</i></p> <p>Yes No Borderline Don't know Refused</p>
Expected Periodicity	Periodic.

Comments

Persons are considered to have diabetes if they respond “yes” to either of the two questions listed above in the DENOMINATOR section. Those who respond “borderline” are not included. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are also excluded.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



5-2. Prevent diabetes.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	17.11 (Diabetes and Chronic Disabling Conditions) (also 2.24).
Measure	Rate per 1,000 population (age adjusted, 3-year average—see Comments).
Baseline	3.5 (1994–96).
Numerator	Number of persons aged 18 years and older who report being diagnosed with diabetes in the past 12 months.
Denominator	Number of persons aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1996 National Health Interview Survey:

- *During the past 12 months did any one in the family (read names) have diabetes?*

[If yes:]

- *Who was this?*

- *When was diabetes first noticed?*
 - (1) *Within the past 2 weeks*
 - (2) *2 weeks to 3 months*
 - (3) *Over 3 months to 1 year*
 - (4) *Over 1 year to 5 years*
 - (5) *Over 5 years*

Expected Periodicity	Annual.
Comments	<p>Respondents who reported that the diabetes was first noticed within the past year (responses 1 through 3 listed above) are considered to have been diagnosed with diabetes in the past 12 months.</p> <p>The measure uses a 3-year moving average to reliably report data for select population groups that have small sample sizes.</p> <p>NHIS was redesigned in 1997. Diabetes incidence questions were not included in the 1997 or 1998 data collection years. The 1999 NHIS includes questions on diabetes incidence.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment—see Part A, section 5.</p> <p>See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.</p>



5-3. Reduce the overall rate of diabetes that is clinically diagnosed.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	17.11 (Diabetes and Chronic Disabling Conditions) (also 2.24), age adjusted to the 2000 population.
Measure	Rate per 1,000 population (age adjusted—see Comments).
Baseline	40 (1997).
Numerator	Number of persons who report ever being diagnosed with diabetes.

Denominator	Number of persons.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Health Interview Survey:</p> <p>[For children under 18 years:]</p> <p>➤ <i>Has a doctor or health professional told you that {sample child} has any of these conditions?</i></p> <p>[List of conditions includes diabetes]</p> <p>[For adults 18 years and older:]</p> <p>[For females:]</p> <p>➤ <i>Other than during pregnancy, have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?</i></p> <p>[For males:]</p> <p>➤ <i>Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?</i></p> <p>Yes No Borderline Don't know Refused</p>
Expected Periodicity	Annual.
Comments	<p>Adults are considered to have diabetes if they respond "yes" to either of the two questions listed above. Those who respond "borderline" are not included. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are also excluded.</p> <p>Children are considered to have diabetes if the adult proxy respondent reports that they have ever been told by a doctor that the child has diabetes.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p>
Comments	See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



5-4. Increase the proportion of adults with diabetes whose condition has been diagnosed.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	68 (1988–94).
Numerator	Number of adults aged 20 years and older who report that they have ever being diagnosed with diabetes.
Denominator	Number of adults aged 20 years and older who have a fasting blood glucose level of 126 mg/dl.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1988–94 National Health and Nutrition Examination Survey:</p> <p>➤ <i>Have you ever been told by a doctor that you have diabetes or sugar diabetes?</i></p> <p>[For female, if yes:]</p> <ul style="list-style-type: none">○ <i>Were you pregnant when you were told that you had diabetes?</i>○ <i>Other than during pregnancy, has a doctor ever told you that you have diabetes or sugar diabetes?</i>
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>Persons are considered to have diabetes if they respond that they have ever been told by a doctor that they have diabetes or sugar diabetes. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are excluded.</p> <p>The undiagnosed population with diabetes is based on the American Diabetes Association criteria.¹</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p>

See Part C for a description of NHANES and Appendix A for focus area contact information.



5-5. Reduce the diabetes death rate.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Adapted from 17.9 (Diabetes and Chronic Disabling Conditions), age adjusted to the 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	75 (1997).
Numerator	Number of deaths due to diabetes (ICD-9 code 250) reported as the underlying or multiple cause of death.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Diabetes-related mortality data are derived from the multiple-cause-of-death files. Data include all mentions of diabetes on the death certificate, whether as an underlying or a multiple cause of death. Diabetes is approximately three times as likely to be listed as multiple cause of death than as underlying cause.²</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p>

This objective differs from Healthy People 2000 objective 17.9, which adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.

See Part C for a description of NVSS and Appendix A for focus area contact information.



5-6. Reduce diabetes-related deaths among persons with diabetes.

National Data Sources	National Vital Statistics System (NVSS), CDC, NCHS; National Health Interview Survey (NHIS), CDC, NCHS.
State Data Sources	National Vital Statistics System (NVSS), CDC, NCHS; Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population (age adjusted—see Comments).
Baseline	8.8 (1997).
Numerator	Number of deaths due to diabetes (ICD-9 code 250) reported as the underlying or multiple cause of death.
Denominator	Number of persons who report that they have ever been diagnosed with diabetes.
Population Targeted	U.S. resident population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	For denominator, see Questions Used To Obtain the National Data provided with objective 5-3.
Expected Periodicity	Annual.
Comments	The numerator and denominator of this measure refer to slightly different populations. The numerator includes all U.S. residents; the denominator includes only the U.S. civilian, noninstitutionalized population.

Adults are considered to have diabetes if they respond “yes” to either of the two questions listed in the DENOMINATOR section of objective 5-3. Those who respond “borderline” are not included. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are also excluded.

Children are considered to have diabetes if the adult proxy respondent reports that they have ever been told by a doctor that the child has diabetes. See Questions Used To Obtain the National Data for objective 5-3.

Diabetes-related mortality data are derived from the multiple-cause-of-death files. Data include all mentions of diabetes on the death certificate, whether as an underlying or a multiple cause of death. Diabetes is approximately three times as likely to be listed as multiple cause of death than as underlying cause.²

Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion of age adjustment, see Part A, section 5.

See Part C for a description of NVSS and BRFSS and Appendix A for focus area contact information.



5-7. Reduce deaths from cardiovascular disease in persons with diabetes.

National Data Sources	National Vital Statistics System (NVSS), CDC, NCHS; National Health Interview Survey (NHIS), CDC, NCHS.
State Data Sources	National Vital Statistics System (NVSS), CDC, NCHS; Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	343 (1997).

Numerator	Number of deaths due to cardiovascular disease as an underlying cause (ICD-9 codes 390-448), among persons who had diabetes listed (ICD-9 code 250) as a multiple cause of death.
Denominator	Number of persons who report that they have ever been diagnosed with diabetes.
Population Targeted	U.S. resident population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	For denominator, see Questions Used To Obtain the National Data provided with objective 5-3.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 5-6 for more information.



5-8. (Developmental) Decrease the proportion of pregnant women with gestational diabetes.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed national data source is the National Vital Statistics System (NVSS), CDC, NCHS.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>
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5-9. (Developmental) Reduce the frequency of foot ulcers in persons with diabetes.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed national data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.</p>
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Beginning in 1999, NHANES collects information that can be used as a proxy for foot ulcers. The proxy measure that is proposed will track peripheral neuropathy as well as brachial ankle blood pressure index, which indicates peripheral vascular disease.

See Part C for a description of NHANES and BRFSS and Appendix A for focus area contact information.



5-10. Reduce the rate of lower extremity amputations in persons with diabetes.

National Data Sources	National Hospital Discharge Survey (NHDS), CDC, NCHS; National Health Interview Survey (NHIS), CDC, NCHS.
State Data Sources	State hospital discharge data systems; Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 17.10 (Diabetes and Chronic Disabling Conditions).
Measure	Rate per 1,000 population (age adjusted—see Comments).
Baseline	4.1 (1997).
Numerator	Number of hospital discharges among U.S. civilian persons with diabetes (ICD-9-CM code 250) as any listed diagnosis and amputation of the lower limb (ICD-9-CM procedure code 84.1) as any listed procedure.
Denominator	Number of persons in the NHIS population who report that they have ever been diagnosed with diabetes.
Population Targeted	U.S. civilian population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	For denominator, see Questions Used To Obtain the National Data provided with objective 5-3.
Expected Periodicity	Annual.

Comments

The numerator and denominator of this measure refer to slightly different populations. The numerator includes the U.S. civilian population; the denominator includes only the U.S. civilian, noninstitutionalized population.

The numerator is obtained from the National Hospital Discharge System (NHDS) and uses any mention ICD-9-CM procedure code 84.1 to define amputation of the lower limb and ICD-9-CM code 250 as any listed diagnosis to identify persons with diabetes.³ Amputations due to trauma are not included.

Adults are considered to have diabetes if they respond “yes” to either of the two questions listed in the DENOMINATOR section of objective 5-3. Those who respond “borderline” are not included. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are also excluded.

Children are considered to have diabetes if the adult proxy respondent reports that they have ever been told by a doctor that the child has diabetes. For specific questions, see Questions Used To Obtain the National Data for objective 5-3.

Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.

This objective is a modification of Healthy People 2000 objectives 17.10 and 17.10c, which tracked the proportion of persons with diabetes who had a hospital discharge with an amputation of the lower limb (excluding amputations due to trauma), using ICD-9-CM procedure codes 84.11 and 84.12. This measure expands the definition of the amputation of the lower limb to ICD-9-CM procedure code 84.1 and is age adjusted to the 2000 standard population.

See Part C for a description of NHDS, NHIS, and BRFSS and Appendix A for focus area contact information.



5-11. (Developmental) Increase the proportion of adults with diabetes who obtain an annual urinary microalbumin measurement.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed national data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCHS.</p> <p>See Part C for a description of BRFSS and Appendix A for focus area contact information.</p>
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5-12. Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year.

National Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	24 (1998) (Selected States—see Comments).
Numerator	Number of persons aged 18 years and older who report they have ever been diagnosed with diabetes and report that a doctor, nurse, or other health professional has checked the respondent's glycosylated hemoglobin (HbA _{1c}) one or more times in the past year.
Denominator	Number of persons aged 18 years and older who report they have ever been diagnosed with diabetes.
Population Targeted	U.S. civilian, noninstitutionalized population (selected States, see Comments).
Questions Used To Obtain the National Data	From the 1998 Behavioral Risk Factor Surveillance System:

[NUMERATOR:]

- *About how many times in the last year has a doctor, nurse, or other health professional checked you for glycosylated hemoglobin “A one C”?*

[DENOMINATOR:]

- *Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?*

[For females, if yes:]

- *Was this only when you were pregnant?*

- *About how many times in the last year have you seen a doctor, nurse, or other health professional for your diabetes?*

Expected Periodicity

Annual.

Comments

Persons are considered to have diabetes if they have ever been told by a doctor or health professional that they have diabetes or sugar diabetes. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are excluded. Persons are considered to have been measured for glycosylated hemoglobin if they have seen a health professional for their diabetes in the past year at least once and have been checked for HbA_{1c} one or more times in the past year.

Data for this objective are collected using the core component and an optional module of the BRFSS, which is made available to States for administration annually. The number of States that select the diabetes module varies every year. In 1998, 39 States used the optional diabetes module. The measure is the mean of data for the reporting States.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of BRFSS and Appendix A for focus area contact information.



5-13. Increase the proportion of adults with diabetes who have an annual dilated eye examination.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	17.23 (Diabetes and Chronic Disabling Conditions), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	47 (1998).
Numerator	Number of persons aged 18 years and older who report that they have ever been told by a doctor that they have diabetes and report that they had a dilated eye examination in the past year.
Denominator	Number of persons aged 18 years and older who report that they have ever been told by a doctor that they have diabetes.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>[NUMERATOR:]</p> <p>➤ <i>Have you EVER had an eye examination in which the pupils were dilated? This would have made you temporarily sensitive to bright light.</i></p> <p>[If yes:]</p> <p>○ <i>When was the last time you had this examination?</i></p> <p>(1) <i>A year ago or less</i> (2) <i>More than 1 year but less than 2 years</i> (3) <i>More than 2 years but less than 3 years</i> (4) <i>More than 3 years but less than 5 years</i> (5) <i>Over 5 years ago</i></p> <p>[DENOMINATOR:]</p> <p>[For females:]</p> <p>➤ <i>Other than during pregnancy, have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?</i></p>

[For males:]

- *Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?*

Yes
No
Borderline
Don't know
Refused

Expected Periodicity

Periodic.

Comments

The numerator is limited to only the persons who reported that they have seen a health professional for an eye examination “a year ago or less.”

Persons are considered to have diabetes if they respond “yes” to either of the two questions listed above in the DENOMINATOR section. Those who respond “borderline” are not included. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are also excluded.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

State-level data are available from the BRFSS, which uses a slightly different question than the NHIS to determine the last time the respondent obtained a dilated eye examination. The question from the 1998 Behavioral Risk Factor Surveillance System follows:

- *When was the last time you had an eye examination in which the pupils were dilated? This would have made you temporarily sensitive to bright light.*

- 1) Within the past month (0 to 1 month ago)*
- 2) Within the past year (1 to 12 months ago)*
- 3) Within the past 2 years (1 to 2 years ago)*
- 4) 2 or more years ago*

See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



5-14. Increase the proportion of adults with diabetes who have at least an annual foot examination.

National Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	55 (1998) (selected States—see Comments).
Numerator	Number of adults aged 18 years and older with diabetes who report that they have seen a health professional for diabetes and have had their feet checked for any sores or irritations.
Denominator	Number of adults aged 18 years and older who report that they have ever been told that they have diabetes.
Population Targeted	Civilian, noninstitutionalized population (selected States—see Comments).
Questions Used To Obtain the National Data	<p>From the 1998 Behavioral Risk Factor Surveillance System:</p> <p>[NUMERATOR:]</p> <p>➤ <i>About how many times in the last year has a health professional checked your feet for any sores or irritations?</i></p> <p>[DENOMINATOR:]</p> <p>➤ <i>Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?</i></p> <p>[For females, if yes:]</p> <p>○ <i>Was this only when you were pregnant?</i></p>
Expected Periodicity	Annual.

Comments

Persons are considered to have diabetes if they had ever been told by a doctor or health professional that they have diabetes or sugar diabetes. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are excluded. Persons are considered to have had a foot examination if their feet had been checked one or more times in the past year.

Data for this objective are collected using the core component and an optional module of the BRFSS, which is made available to States for administration annually. The number of States that select the diabetes module varies every year. In 1998, 39 States used the optional diabetes module. The measure is the mean of data for the reporting States.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of BRFSS and Appendix A for focus area contact information.



5-15. Increase the proportion of persons with diabetes who have at least an annual dental examination.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	58 (1997).
Numerator	Number of persons aged 2 years and older who report ever being diagnosed with diabetes and report that they have seen or spoken to a dentist in the past year.
Denominator	Number of persons aged 2 years and older who have ever been told that they have diabetes.

Population Targeted

U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data

From the 1997 National Health Interview Survey:

[NUMERATOR:]

- *About how long has it been since you last saw or talked to a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as hygienists.*
 - (1) 6 months or less
 - (2) More than 6 months but not more than a year ago
 - (3) More than 1 year ago but less than 3 years ago
 - (4) More than 3 years
 - (5) Never

[DENOMINATOR:]

[For children under 18 years:]

- *Has a doctor or health professional told you that {sample child} has any of these conditions?*

[List of conditions includes diabetes]

[For adults 18 years and older:]

[For females:]

- *Other than during pregnancy, have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?*

[For males:]

- *Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?*

Yes

No

Borderline

Don't know

Refused

Expected Periodicity

Annual.

Comments

Adults are considered to have diabetes if they respond "yes" to either of the two questions listed above in the DENOMINATOR section. Those who respond "borderline" are not included. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are also excluded.

Children are considered to have diabetes if the adult proxy respondent reports that they have ever been told by a doctor that the child has diabetes.

An annual dental examination is defined as seeing or speaking to a dental professional in the past year.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



5-16. Increase the proportion of persons with diabetes who take aspirin at least 15 times per month.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	20 (1988–94).
Numerator	Number of persons aged 40 years and older with diabetes who reported taking aspirin products at least 15 times in the past month.
Denominator	Number of persons aged 40 years and older who report that they have ever been told that they have diabetes.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1988–94 National Health and Nutrition Examination Survey:</p> <p>[NUMERATOR:]</p> <ul style="list-style-type: none">➤ <i>In the past month, have you taken any aspirin, Anacin, Bufferin, Ecotin, Ascriptin, or Midol?</i>➤ <i>How often did you take aspirin, Anacin, Bufferin, Ecotin, Ascriptin, or Midol during the past month?</i> <p>[DENOMINATOR:]</p> <ul style="list-style-type: none">➤ <i>Have you ever been told by a doctor that you have diabetes or sugar diabetes?</i>

[For female, if yes:]

- *Were you pregnant when you were told that you had diabetes?*
- *Other than during pregnancy, has a doctor ever told you that you have diabetes or sugar diabetes?*

Expected Periodicity Annual, beginning with 1999 data.

Comments

Persons are considered to have diabetes if they respond that they have ever been told by a doctor that they have diabetes or sugar diabetes. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are excluded.

Persons are considered to have used aspirin products if they reported using aspirin, Anacin, Bufferin, Ecotin, Ascriptin, or Midol 15 or more times in the past month.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHANES and Appendix A for focus area contact information.



5-17. Increase the proportion of adults with diabetes who perform self-blood-glucose-monitoring at least once daily.

National Data Source Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

State Data Source Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

Healthy People 2000 Objective Not applicable.

Measure Percent (age adjusted—see Comments).

Baseline 42 (1998) (selected States—see Comments).

Numerator Number of persons aged 18 years and older with diabetes who report that they check their blood for glucose or sugar by themselves or by a family member or friend (excludes health professional) at least once a day.

Denominator Number of persons aged 18 years and older who report that they have ever been told they have diabetes.

Population Targeted Civilian, noninstitutionalized population (selected States, see Comments).

Questions Used To Obtain the National Data From the 1998 Behavioral Risk Factor Surveillance System:

[NUMERATOR:]

- *About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do not include times when checked by a health professional.*

_____ *Times per day*
_____ *Times per week*
_____ *Times per month*
_____ *Times per year*

[DENOMINATOR:]

- *Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?*

[For females, if yes:]

- *Was this only when you were pregnant?*

Expected Periodicity Annual.

Comments Persons are considered to have diabetes if they have ever been told by a doctor or health professional that they have diabetes or sugar diabetes. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are excluded. Persons are considered to have had a foot examination if their feet have been checked one or more times in the past year.

Data for this objective are collected using the core component and an optional module of the BRFSS, which is made available to States for administration annually. The number of States that select the diabetes module varies every year. In 1998, 39 States used the optional diabetes module. The measure is the mean of data for the reporting States.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of BRFSS and Appendix A for focus area contact information.



References

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2. National Center for Health Statistics. *Healthy People 2000 Review, 1998–99*. Hyattsville, MD: Public Health Service, 1999.
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6

Disability and Secondary Conditions

- 6-1 Standard definition of people with disabilities in data sets
- 6-2 Feelings and depression among children with disabilities
- 6-3 Feelings and depression interfering with activities among adults with disabilities
- 6-4 Social participation among adults with disabilities
- 6-5 Sufficient emotional support among adults with disabilities
- 6-6 Satisfaction with life among adults with disabilities
- 6-7 Congregate care of children and adults with disabilities
- 6-7a Adults aged 22 years and older
- 6-7b Persons aged 21 years and under
- 6-8 Employment parity
- 6-9 Inclusion of children and youth with disabilities in regular education programs
- 6-10 Accessibility of health and wellness programs
- 6-11 Assistive devices and technology
- 6-12 Environmental barriers affecting participation in activities
- 6-13 Surveillance and health promotion programs
- 6-13a States and the District of Columbia
- 6-13b Tribes

6-1. Include in the core of all relevant Healthy People 2010 surveillance instruments a standardized set of questions that identify “people with disabilities.”

National Data Source	CDC, NCEH, Office on Disability and Health.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	0 (1999).
Numerator	Number of relevant surveillance instruments used to measure Healthy People 2010 objectives that include in their core standardized questions that identify people with disabilities.
Denominator	Number of relevant instruments used to measure Healthy People 2010 objectives.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The number of instruments to be included in this measure was under review at the time of publication.</p> <p>No standardized set of questions that identify people with disabilities currently exists.</p> <p>CDC has proposed that a standardized set of questions on disability status be developed. As standard questions are adopted by the data systems, the data produced from them will be incorporated into the Healthy People 2010 objectives that specifically identify people with disabilities. This presents the opportunity in the future to have a standard definition of people with disabilities that can be used across data systems and geographic levels.</p> <p>See Appendix A for focus area contact information.</p>



6-2. Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	31 (1997).
Numerator	Number of children and adolescents aged 4 to 11 years with disabilities who are reported to be unhappy, sad, or depressed.
Denominator	Number of children and adolescents aged 4 to 11 years with disabilities.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997 National Health Interview Survey:

[NUMERATOR:]

- *During the past 6 months has (Person) been unhappy, sad, or depressed?*

[DENOMINATOR:]

- *I am now going to ask you about (your/the) general health (of family members) and the effects of any physical, mental, or emotional health problems.*

[For children under 5:]

- *(Are/Is) (Person) limited in the kind or amount of play activities he/she/they can do because of a physical, mental or emotional problem?*

[For children 3 to 17:]

- *Because of a physical, mental or emotional problem (do/does) (you/anyone) in the family need the help of other persons with PERSONAL CARE NEEDS, such as eating, bathing, dressing, or getting around inside this home?*

[For children 5 to 17:]

- *Because of a physical, mental or emotional problem (do/does) (you/anyone) in the family need the help of other persons in handling ROUTINE NEEDS, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?*

[For children under 18:]

- *Do any of the children under 18 in this family receive Special Education or Early Intervention Services?*
- *Because of a health problem, (do/does) (you/anyone) in the family have difficulty walking without using any special equipment?*
- *(Are/Is) (you/anyone) in the family LIMITED IN ANY WAY in any activities because of difficulty remembering or because {you/they} experience periods of confusion?*
- *(Are/Is) (you/anyone) in the family LIMITED IN ANY WAY in any activities because of physical, mental or emotional problems?*
- *Does (Person) have an impairment or health problem that requires {him/her} to use special equipment, such as a brace, a wheelchair, or a hearing aid (excluding ordinary eyeglasses or corrective shoes)?*

Expected Periodicity

Annual.

Comments

Children and adolescents aged 4 to 11 are defined as having a disability if the proxy adult respondent responds “yes” to any of the limitation, special services, or special equipment questions listed above in the DENOMINATOR section.

A child/adolescent is considered sad, unhappy or depressed if any of these feelings have been observed by the proxy adult respondent during the past 6 months.

Baseline percents are based on data obtained in the last two quarters of the 1997 NHIS collection period.

This objective was intended to target all children and adolescents aged 2 to 18 years. However with the 1997 NHIS, it was not possible to combine data for the entire age range into one measure. Instead, proxy data for children and adolescents aged 4 to 11 years have been provided.

See Part C for a description of NHIS and Appendix A for focus area contact information.

6-3. Reduce the proportion of adults with disabilities who report feelings such as sadness, unhappiness, or depression that prevent them from being active.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	28 (1997).
Numerator	Number of adults aged 18 years and older with disabilities who report negative feelings that prevented them from being active in the last 30 days.
Denominator	Number of adults aged 18 years and older with disabilities.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Health Interview Survey:</p> <p>[NUMERATOR:]</p> <p>➤ <i>During the PAST 30 DAYS, how often did you feel</i></p> <p><i>... so sad that nothing could cheer you up?</i></p> <p><i>... nervous?</i></p> <p><i>... restless or fidgety?</i></p> <p><i>... hopeless?</i></p> <p><i>... that everything was an effort?</i></p> <p><i>... worthless?</i></p> <p><i>ALL of the time</i></p> <p><i>MOST of the time</i></p> <p><i>SOME of the time</i></p> <p><i>A LITTLE of the time</i></p> <p><i>NONE of the time</i></p> <p><i>Refused/Not ascertained/Don't know</i></p>

[Asked of persons who at least some of the time, have felt sad, nervous, restless or fidgety, hopeless, that everything was an effort, or worthless in the past 30 days.]

- *We just talked about a number of feelings you had during the PAST 30 DAYS. Altogether, how MUCH did these feelings interfere with your life or activities: a lot, some, a little, or not at all?*

[DENOMINATOR:]

- *I am now going to ask you about (your/the) general health (of family members) and the effects of any physical, mental, or emotional health problems.*
- *Because of a physical, mental or emotional problem (do/does) (you/anyone) in the family need the help of other persons with PERSONAL CARE NEEDS, such as eating, bathing, dressing, or getting around inside this home?*
- *Because of a physical, mental or emotional problem (do/does) (you/anyone) in the family need the help of other persons in handling ROUTINE NEEDS, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?*
- *Does a physical, mental or emotional problem NOW keep (you/any family members aged 18 and older) from working at a job or business?*
- *(Are any family members aged 18 and older) limited in the kind OR amount of work (you/they) can do because of a physical, mental or emotional problem?*
- *Because of a health problem, (do/does) (you/anyone) in the family have difficulty walking without using any special equipment?*
- *(Are/Is) (you/anyone) in the family LIMITED IN ANY WAY in any activities because of difficulty remembering or because {you/they} experience periods of confusion?*
- *(Are/Is) (you/anyone) in the family LIMITED IN ANY WAY in any activities because of physical, mental or emotional problems?*
- *Do you now have any health problems that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?*

Expected Periodicity

Annual.

Comments

Adults aged 18 years and older are defined as having a disability if a “yes” response is obtained to any of the limitation or special equipment questions listed above in the DENOMINATOR section.

An adult is considered to have feelings that prevent them from being active if he/she answered the feelings interfered “a lot” or “some” with their life or activities.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



6-4. Increase the proportion of adults with disabilities who participate in social activities.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	95.4 (1997).
Numerator	Number of adults aged 18 years and older with disabilities who report participation in social activities.
Denominator	Number of adults aged 18 years and older with disabilities.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997 National Health Interview Survey:

[NUMERATOR:]

- *By yourself, and WITHOUT using any special equipment, how difficult is it for you to . . . Go out to things like shopping, movies, or sporting events?*

Not at all difficult

Only a little difficult

Somewhat difficult

Very difficult

Can't do at all

Do not do this activity

Refused/Not ascertained/Don't know

[DENOMINATOR:]

See Questions Used To Obtain the National Data (DENOMINATOR) provided with objective 6-3.

Expected Periodicity

Annual.

Comments

Adults aged 18 years and older are defined as having a disability if he/she responds "yes" to any of the limitation questions listed in the DENOMINATOR section for objective 6-3.

An adult is considered to participate in social activities if he/she responded "not at all difficult," "only a little difficult," "somewhat difficult," or "very difficult" to the question listed in the NUMERATOR section above.

This objective was intended to measure whether persons with disabilities engage in social activity. It is currently possible to measure only how difficult it is for someone to participate in social activities from the NHIS, thus a proxy measure has been used. The 1999 BRFSS piloted another set of participation questions in Colorado. Future periodic NHIS modules or BRFSS surveys may include these or similar questions in the next few years.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



6-5. Increase the proportion of adults with disabilities reporting sufficient emotional support.

National Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	71 (1998) (10 States and the District of Columbia—see Comments).
Numerator	Number of adults aged 18 years and older with disabilities who report receiving sufficient emotional support.
Denominator	Number of adults aged 18 years and older with disabilities.
Population Targeted	Civilian, noninstitutionalized population of selected States (see Comments).
Questions Used To Obtain the National Data	<p>From the 1998 Behavioral Risk Factor Surveillance System:</p> <p>[NUMERATOR:]</p> <p>➤ <i>How often do you get the social and emotional support you need?</i></p> <p><i>Always</i> <i>Usually</i> <i>Sometimes</i> <i>Rarely</i> <i>Never</i> <i>Refused/Not ascertained/Don't know</i></p> <p>[DENOMINATOR:]</p> <p>➤ <i>Are you limited in any way in any activities because of any impairment or health problem?</i></p> <p>➤ <i>If you use special equipment or help from others to get around, what type do you use?</i></p>
Expected Periodicity	Periodic.

Comments	<p>For this objective, adults with disabilities are defined as persons aged 18 years and older who report being limited in any activity because of impairments or health problems or who require special equipment. An adult is considered to have sufficient social support if he/she reported “always” or “usually” to the question listed in the NUMERATOR section above.</p> <p>1998 baseline data are based on responses from 10 States and the District of Columbia.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.</p> <p>See Part C for a description of BRFSS and Appendix A for focus area contact information.</p>
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6-6. Increase the proportion of adults with disabilities reporting satisfaction with life.

National Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	87 (1998) (10 States and the District of Columbia—see Comments).
Numerator	Number of adults aged 18 years and older with disabilities who report satisfaction with life.
Denominator	Number of adults aged 18 years and older with disabilities.
Population Targeted	Civilian, noninstitutionalized population of selected States (see Comments).
Questions Used To Obtain the National Data	From the 1998 Behavioral Risk Factor Surveillance System:

[NUMERATOR:]

- *In general, how satisfied are you with your life?*

Very satisfied

Satisfied

Dissatisfied

Very dissatisfied

Refused/Not ascertained/Don't know

[DENOMINATOR:]

- *Are you limited in any way in any activities because of any impairment or health problem?*

- *If you use special equipment or help from others to get around, what type do you use?*

Expected Periodicity

Periodic.

Comments

For this objective, adults with disabilities are defined as persons 18 years and older who report being limited in any activity because of impairments or health problems or who require special equipment. An adult is considered to be satisfied with life if he/she reported being "very satisfied" or "satisfied" to the question listed in the NUMERATOR section above.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

1998 baseline data are based on responses from 10 States and the District of Columbia.

See Part C for a description of BRFSS and Appendix A for focus area contact information.



6-7. Reduce the number of people with disabilities in congregate care facilities, consistent with permanency planning principles.

6-7a. Persons aged 22 years and older in 16 or more bed congregate facilities.

National Data Source

Survey of U.S. Residential Facilities, University of Minnesota.

State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	93,362 (1997).
Numerator	Number of adults aged 22 years and older in congregate care facilities with 16 or more beds.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	From the 1997 Survey of U.S. Residential Facilities: ➤ <i>Facility type, number of beds, age of residents.</i>
Expected Periodicity	Annual.
Comments	State residential facilities are asked to complete a form and the information is abstracted, analyzed by investigators at the University of Minnesota, and reported in Residential Services for Persons with Developmental Disabilities: Status and Trends. ¹ See Appendix A for focus area contact information.



6-7b. Persons aged 21 years and under in congregate care facilities.

National Data Source	Survey of U.S. Residential Facilities, University of Minnesota.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	24,300 (1997).
Numerator	Number of persons aged 22 years and under in congregate care facilities with 16 or more beds.
Denominator	Not applicable.
Population Targeted	U.S. resident population.

Questions Used To Obtain the National Data	From the 1997 Survey of U.S. Residential Facilities:
Expected Periodicity	➤ <i>Facility type, number of beds, age of residents.</i>
Comments	Annual. State residential facilities are asked to complete a form and the information is abstracted, analyzed by investigators at the University of Minnesota, and reported in Residential Services for Persons with Developmental Disabilities: Status and Trends. ¹ See Appendix A for focus area contact information.



6-8. Eliminate disparities in employment rates between working-aged adults with and without disabilities.

National Data Source	Survey of Income and Program Participation (SIPP), Department of Commerce, Bureau of Census.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	52 (1994–95).
Numerator	Number of adults aged 21 to 64 years with disabilities who are employed.
Denominator	Number of adults aged 21 to 64 years with disabilities.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From Wave 6 of the 1993 Survey of Income and Program Participation: [NUMERATOR:] ➤ <i>During the 4-month period outlined on this calendar, that is from (4 months ago) through (last month), did (Person) have a job or business, either full time or part time, even for only a few days? (Mark “yes” for active duty in the Armed Forces, any temporary or part-time work, and work without pay in a family business or farm)</i>

- *Even though (Person) did not have a job during this period, did (Person) do any work at all that earned some money?*
- *Did (Person) have a job or business, either full or part time, during EACH of the weeks in this period?*
- *During the weeks that (Person) did not have a job, did (Person) do any work at all that earned some money?*

[DENOMINATOR:]

- *(Mark by observation if apparent.) Does (Person) use any of the following aids to get around?*
 - a. A cane, crutches, or a walker
 - b. A wheelchair

[If "yes" to a or b above:]

- *Has (Person) used (Aid mentioned in a or b above) for six months or longer?*
- *Does (Person) have difficulty seeing the words and letters in ordinary newspaper print even when wearing glasses or contact lenses if ... usually wears them?*
- *Does (Person) have any difficulty hearing what is said in normal conversation with another person (using a hearing aid if (Person) usually wears one)?*
- *Because of a health condition or problem, does (Person) have any difficulty having his/her speech understood?*
- *Does (Person) have any difficulty lifting and carrying something as heavy as 10 lbs., such as a full bag of groceries?*
- *Does (Person) have any difficulty climbing a flight of stairs without resting?*
- *Does (Person) have any difficulty walking a quarter of a mile - about 3 city blocks?*
- *Does (Person) have any difficulty using the telephone?*

- *Because of a physical or mental health condition, does (Person) have difficulty doing any of the following by himself/herself (exclude the effects of temporary conditions)? (If an aid is used, ask whether the person has difficulty even when using the aid.)*

Getting around INSIDE the home?

Going OUTSIDE the home, for example to shop or visit a doctor's office?

Getting in and out of bed or a chair?

Taking a bath or shower?

Dressing?

Walking?

Eating?

Using the toilet, including getting to the toilet?

Keeping track of money and bills?

Preparing meals?

Doing light housework, such as washing dishes or sweeping a floor?

Taking the right amount of prescribed medicine at the right time?

- *Does (Person) have –*

Mental retardation?

A developmental disability such as autism or cerebral palsy?

Alzheimer's disease, senility, dementia?

Any other mental or emotional conditions?

- *We have recorded that (Person)'s health or condition limits the kind or amount of work (Person) can do. Is that correct?*
- *Does (Person) have a physical, mental, or other health condition which limits the kind or amount of work (Person) can do?*
- *Does (Person) have a physical, mental, or other health condition which limits the kind or amount of work (Person) can do around the house?*

Expected Periodicity

Periodic.

Comments

Adults aged 21 to 64 years are defined as having a disability if he/she has used a cane, crutch, walker or wheelchair to get around for 6 months or longer or responds "yes" to any of the limitation questions listed in the DENOMINATOR section above.

An adult is considered be employed if he/she answered "yes" to any of the job-related questions listed in the NUMERATOR section above.

Additional information on disability data from the SIPP, can be found at the following Web site:
www.census.gov/hhes/www/disable/dissipp.html.

See Appendix A for focus area contact information.



6-9. Increase the proportion of children and youth with disabilities who spend at least 80 percent of their time in regular education programs.

Comments

A complete operational definition was not specified at the time of publication.

See Appendix A for focus area contact information.



6-10. (Developmental) Increase the proportion of health and wellness and treatment programs and facilities that provide full access for people with disabilities.

Comments

An operational definition could not be specified at the time of publication. A proposed national data source is the National Independent Living Centers Network.

See Appendix A for focus area contact information.



6-11. (Developmental) Reduce the proportion of people with disabilities who report not having the assistive devices and technology needed.

Comments

An operational definition could not be specified at the time of publication. A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

See Appendix A for focus area contact information.



6-12. (Developmental) Reduce the proportion of people with disabilities reporting environmental barriers to participation in home, school, work, or community activities.

Comments

An operational definition could not be specified at the time of publication. A possible data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

See Appendix A for focus area contact information.



6-13. Increase the number of Tribes, States, and the District of Columbia that have public health surveillance and health promotion programs for people with disabilities and caregivers.

6-13a. States and the District of Columbia

Comments

A complete operational definition was not specified at the time of publication.

See Appendix A for focus area contact information.



6-13b. (Developmental) Tribes

Comments

An operational definition could not be specified at the time of publication. A potential data source is the Office on Disability and Health, CDC, NCEH.

See Appendix A for focus area contact information.



Reference

1. Prouty, R., and Lakin, K.C., eds. *Residential Services for Persons With Developmental Disabilities: Status and Trends Through 1996*. Report No. 49. Minneapolis, MN: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, 1997.

7

Educational and Community-Based Programs

School Setting

- 7-1 High school completion
- 7-2 School health education
 - 7-2a All components
 - 7-2b Unintentional injury
 - 7-2c Violence
 - 7-2d Suicide
 - 7-2e Tobacco use and addiction
 - 7-2f Alcohol and other drug use
 - 7-2g Unintended pregnancy, HIV/AIDS, and STD infection
 - 7-2h Unhealthy dietary patterns
 - 7-2i Inadequate physical activity
 - 7-2j Environmental health
- 7-3 Health-risk behavior information for college and university students
- 7-4 School nurse-to-student ratio
 - 7-4a All middle, junior high, and senior high schools
 - 7-4b Senior high schools
 - 7-4c Middle and junior high schools
 - 7-4d Elementary schools

Worksite Setting

- 7-5 Worksite health promotion programs
 - 7-5a Worksites with fewer than 50 employees
 - 7-5b Worksites with 50 or more employees
 - 7-5c Worksites with 50 to 99 employees
 - 7-5d Worksites with 100 to 249 employees

- 7-5e Worksites with 250 to 749 employees
- 7-5f Worksites with 750 or more employees
- 7-6 Participation in employer-sponsored health promotion activities

Health Care Setting

- 7-7 Patient and family education
- 7-8 Satisfaction with patient education
- 7-9 Health care organization sponsorship of community health promotion activities

Community Setting and Select Populations

- 7-10 Community health promotion programs
- 7-11 Culturally appropriate and linguistically competent community health promotion programs
 - 7-11a Access to quality health services
 - 7-11b Arthritis, osteoporosis, and chronic back conditions
 - 7-11c Cancer
 - 7-11d Chronic kidney disease
 - 7-11e Diabetes
 - 7-11f Disability and secondary conditions
 - 7-11g Educational and community-based programs
 - 7-11h Environmental health
 - 7-11i Family planning
 - 7-11j Food safety
 - 7-11k Medical product safety
 - 7-11l Health communication
 - 7-11m Heart disease and stroke
 - 7-11n HIV
 - 7-11o Immunizations and infectious diseases
 - 7-11p Injury and violence prevention
 - 7-11q Maternal, infant (and child) health
 - 7-11r Mental health (and mental disorders)
 - 7-11s Nutrition and overweight
 - 7-11t Occupational safety and health
 - 7-11u Oral health
 - 7-11v Physical activity and fitness
 - 7-11w Public health infrastructure
 - 7-11x Respiratory diseases
 - 7-11y Sexually transmitted diseases

- 7-11z Substance abuse (alcohol and other drugs)
- 7-11aa Tobacco use
- 7-11bb Vision and hearing
- 7-12 Older adult participation in community health promotion activities

School Setting

7-1. Increase high school completion.

National Data Source	Current Population Survey (CPS), U.S. Department of Commerce, U.S. Bureau of the Census.
State Data Source	Current Population Survey (CPS), U.S. Department of Commerce, U.S. Bureau of the Census.
Healthy People 2000 Objective	8.2 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	85 (1998).
Numerator	Number of persons 18 to 24 years old not currently enrolled in high school who report that they have received a high school diploma or its equivalent.
Denominator	Persons aged 18 to 24 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 Current Population Survey:</p> <ul style="list-style-type: none">➤ <i>Is (<u>Person</u>) attending or enrolled in regular school?</i>➤ <i>What grade or year is (<u>Person</u>) attending?</i>➤ <i>Was (<u>Person</u>) attending or enrolled in a regular school or college in October, 199_, that is, October of last year?</i>➤ <i>What grade or year was (<u>Person</u>) attending last year?</i>➤ <i>What is the highest level of school (<u>Person</u>) has completed or the highest degree...has received?</i>
Expected Periodicity	Annual.
Comments	<p>High school completion is the proportion of persons aged 18 to 24 years not currently enrolled in high school who report that they have received a high school diploma or the equivalent (such as a General Education Development (GED) certificate), regardless of the type of credential.</p> <p>States are able to report in 3-year averages only. For States with small populations, the 3-year estimates may be unreliable.</p>



- 7-2. Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.**

7-2a. All components

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	School Health Education Profiles (SHEPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	28 (1994).
Numerator	Number of middle, junior, and senior high schools that provide health education on all key behavior and content areas.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.
Questions Used To Obtain the National Data	From the 1994 School Health Policies and Programs Study:

➤ *Now I'd like to ask which health education topics are taught in any of the required courses that we've listed. Please give me the numbers of the topics your school teaches at some time in required courses.*

1. *None of these topics*
2. *Alcohol and other drug use prevention*
3. *Conflict resolution/violence prevention*
4. *Dietary behaviors and nutrition*
5. *Environmental health*
6. *HIV prevention*
7. *Injury prevention and safety*
8. *Physical activity and fitness*
9. *Pregnancy prevention*
10. *Sexually transmitted disease (STD) prevention*
11. *Suicide prevention*
12. *Tobacco use prevention*
13. *Other (List additional topics here): _____*

Expected Periodicity

Periodic.

Comments

A school is considered to provide health education on key risk behavior and content areas if they report having required courses on all the topics listed in the question above.

This objective is adapted from a measure in Healthy People 2000 objective 8.4, which tracked the proportion of elementary and secondary schools that included instruction in six key behavioral areas (unintentional and intentional injury, tobacco use, alcohol and other drug use, sexual behaviors, unhealthy dietary behaviors, physical inactivity) in their health education program. The 2010 measure tracks middle, junior, and senior high schools: it excludes elementary schools. The 2010 measure also includes environmental health.

See Part C for a description of SHPPS and Appendix A for focus area contact information.



7-2b. Unintentional injury.

National Data Source

School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

State Data Source

School Health Education Profiles (SHEPS), CDC, NCCDPHP.

Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	66 (1994).
Numerator	Number of middle, junior, and senior high schools that provide health education on injury prevention and safety.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-2a.
Expected Periodicity	Periodic.
Comments	<p>A school is considered to provide health education on key risk behavior and content areas if they report having a required course on injury prevention and safety.</p> <p>See Comments provided with objective 7-2a for more information.</p>



7-2c. Violence.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	School Health Education Profiles, (SHEPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	58 (1994).
Numerator	Number of middle, junior, and senior high schools that provide health education on conflict resolution/violence prevention.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.

Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-2a.
Expected Periodicity	Periodic.
Comments	<p>A school is considered to provide health education on key risk behavior and content areas if they report having a required course on conflict resolution/ violence prevention.</p> <p>See Comments provided with objective 7-2a for more information.</p>



7-2d. Suicide.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	School Health Education Profiles (SHEPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	58 (1994).
Numerator	Number of middle, junior, and senior high schools that provide health education on suicide prevention.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-2a.
Expected Periodicity	Periodic.
Comments	<p>A school is considered to provide health education on key risk behavior and content areas if they report having a required course on suicide prevention.</p> <p>See Comments provided with objective 7-2a for more information.</p>



7-2e. Tobacco use and addiction.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	School Health Education Profiles (SHEPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	86 (1994).
Numerator	Number of middle, junior, and senior high schools that provide health education on tobacco use prevention.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-2a.
Expected Periodicity	Periodic.
Comments	<p>A school is considered to provide health education on key risk behavior and content areas if they report having a required course on tobacco use prevention.</p> <p>See Comments provided with objective 7-2a for more information.</p>



7-2f. Alcohol and other drug use.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	School Health Education Profiles (SHEPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	90 (1994).

Numerator	Number of middle, junior, and senior high schools that provide health education on alcohol and other drug use prevention.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-2a.
Expected Periodicity	Periodic.
Comments	<p>A school is considered to provide health education on key risk behavior and content areas if they report having a required course on alcohol and other drug use prevention.</p> <p>See Comments provided with objective 7-2a for more information.</p>



7-2g. Unintended pregnancy, HIV/AIDS, and STD infection.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	School Health Education Profiles (SHEPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	65 (1994).
Numerator	Number of middle, junior, and senior high schools that provide health education on (unintended) pregnancy prevention, HIV (AIDS) prevention, and sexually transmitted disease (STD) prevention.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-2a.
Expected Periodicity	Periodic.

Comments	<p>A school is considered to provide health education on key risk behavior and content areas if they report having a required course on (unintended) pregnancy prevention, HIV (AIDS) prevention, and sexually transmitted disease (STD) prevention.</p> <p>See Comments provided with objective 7-2a for more information.</p>
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7-2h. Unhealthy dietary patterns.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	School Health Education Profiles (SHEPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs) and 2.19 (Nutrition).
Measure	Percent.
Baseline	84 (1994).
Numerator	Number of middle, junior, and senior high schools that provide health education on dietary behaviors and nutrition.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-2a.
Expected Periodicity	Periodic.
Comments	A school is considered to provide health education on key risk behavior and content areas if they report having a required course on dietary behaviors and nutrition.

This objective is adapted from measures in Healthy People 2000 objective 8.4, which tracked the proportion of elementary and secondary schools that included instruction in six key behavioral areas (unintentional and intentional injury, tobacco use, alcohol and other drug use, sexual behaviors, unhealthy dietary behaviors, physical inactivity) in their health education program; and Healthy People 2000 objective 2.19, which tracked the proportion of elementary and secondary schools that included instruction in nutrition information. The 2010 measure tracks middle, junior, and senior high schools: it excludes elementary schools. The 2010 measure also includes environmental health.



7-2i. Inadequate physical activity.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	School Health Education Profiles (SHEPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	78 (1994).
Numerator	Number of middle, junior, and senior high schools that provide health education on physical activity and fitness.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-2a.
Expected Periodicity	Periodic.
Comments	A school is considered to provide health education on key risk behavior and content areas if they report having a required course on physical activity and fitness.

See Comments provided with objective 7-2a for more information.

See Part C for a description of SHPPS and Appendix A for focus area contact information.



7-2j. Environmental health.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	School Health Education Profiles (SHEPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 8.4 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	60 (1994).
Numerator	Number of middle, junior, and senior high schools that provide health education on environmental health.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior, and senior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-2a.
Expected Periodicity	Periodic.
Comments	<p>A school is considered to provide health education on key risk behavior and content areas if they report having a required course on environmental health.</p> <p>See Comments provided with objective 7-2a for more information.</p>



7-3. Increase the proportion of college and university students who receive information from their institution on each of the six priority health-risk behavior areas.

National Data Source	National College Health Risk Behavior Survey (NCHRBS), CDC, NCCDPHP.
State Data Source	Not identified.
Healthy People 2000 Objective	8.5 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	6 (1995).
Numerator	Number of undergraduate students who report that they have received information from their college or university on each of the six priority health-risk behavior areas.
Denominator	Number of undergraduate college students in post-secondary institutions.
Population Targeted	Undergraduate college students.
Questions Used To Obtain the National Data	<p>From the 1995 National College Health Risk Behavior Survey:</p> <p>➤ <i>On which health topics have you ever received information from your college or university?</i></p> <ol style="list-style-type: none">1. <i>Tobacco use prevention</i>2. <i>Alcohol and other drug use prevention</i>3. <i>Violence prevention</i>4. <i>Injury prevention and safety</i>5. <i>Suicide prevention</i>6. <i>Pregnancy prevention</i>7. <i>Sexually transmitted disease (STD) prevention</i>8. <i>AIDS or HIV infection prevention</i>9. <i>Dietary behaviors and nutrition</i>10. <i>Physical activity and fitness</i>
Expected Periodicity	Periodic.
Comments	Students were considered as receiving information on each of the six priority health-risk behavior areas if they responded positively to <u>all</u> of the topics listed in the question above.

The six priority health-risk behaviors are: injuries (intentional and unintentional), tobacco use, alcohol and illicit drug use, sexual behaviors that cause unintended pregnancies and sexually transmitted diseases, dietary patterns that cause disease, and inadequate physical activity.

Postsecondary institutions include 2- and 4-year community colleges, private colleges, and universities.

See Appendix A for focus area contact information.



7-4. Increase the proportion of the Nation's elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750.

7-4a. All middle, junior high, and senior high schools.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	28 (1994).
Numerator	Number of middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750.
Denominator	Number of middle, junior, and senior high schools.
Population Targeted	Middle, junior high, and senior high schools.
Questions Used To Obtain the National Data	From the 1994 School Health Policies and Programs Study: <ul style="list-style-type: none">➤ <i>Are there any RN/LPNs who work in the school?</i> [If yes:]<ul style="list-style-type: none">○ <i>Please tell me <u>how many</u> RN/LPNs work in your school, <u>which days of the week</u> each RN is here, and <u>how many hours</u> each RN/LPN is usually here on those days.</i>

[If an RN/LPN doesn't have a regular schedule, ask:]

- *How many total hours per week is this RN/LPN usually in your school?*

Expected Periodicity Periodic.

Comments The nurse-to-student ratio is the number of school nurses divided by the total student enrollment. One school nurse is defined as 30 nurse-hours per week per school.

Total student enrollment of all the schools included in SHPPS is obtained from the Quality Education Data (QED) database. QED's National Education Database covers all educational institutions in the United States and Canada. See <http://www.qeddata.com/> for more information.

See Part C for a description of SHPPS and Appendix A for focus area contact information.



7-4b. Senior high schools.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	26 (1994).
Numerator	Number of senior high schools that have a nurse-to-student ratio of at least 1:750.
Denominator	Number of senior high schools.
Population Targeted	Senior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-4a.
Expected Periodicity	Periodic.
Comments	See Comments provided with 7-4a for more information.

Total student enrollment of the senior high schools included in SHPPS is obtained from the Quality Education Data (QED) database. QED's National Education Database covers all educational institutions in the United States and Canada. See <http://www.qeddata.com/> for more information.



7-4c. Middle and junior high schools.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	32 (1994).
Numerator	Number of middle and junior high schools that have a nurse-to-student ratio of at least 1:750.
Denominator	Number of middle and junior high schools.
Population Targeted	Middle and junior high schools.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-4a.
Expected Periodicity	Periodic.
Comments	See Comments provided with 7-4a for more information. Total student enrollment of the middle and junior high schools included in SHPPS is obtained from the Quality Education Data (QED) database. QED's National Education Database covers all educational institutions in the United States and Canada. See http://www.qeddata.com/ for more information.

7-4d. (Developmental) Elementary schools.

Comments	An operational definition could not be specified at the time of publication.
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The expected national data source is the School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

The expected numerator is the number of elementary schools that have a nurse-to-student ratio of at least 1:750.

The expected denominator is the number of elementary schools.

The nurse-to-student ratio is the number of school nurses divided by the total student enrollment. One school nurse is defined as 30 nurse hours per week per school.

Total student enrollment of the elementary schools included in SHPPS will be obtained from the Quality Education Data (QED) database. QED's National Education Database covers all educational institutions in the United States and Canada. See <http://www.qeddata.com/> for more information.

See Part C for a description of SHPPS and Appendix A for focus area contact information.



Worksite Setting

7-5. Increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees.

7-5a. (Developmental) Worksites with fewer than 50 employees

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the 1999 National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP).

A comprehensive worksite health promotion program contains all of the following elements:

- (1) health education that focuses on skill development and lifestyle behavior change in addition to information dissemination and awareness building, preferably tailored to employees interests and needs;
- (2) supportive social and physical environments, including established norms for healthy behavior and policies that promote health and reduce risk of disease, such as worksite smoking policies, healthy nutrition alternatives in the cafeteria and vending machines, and opportunities for obtaining regular physical activity;
- (3) integration of the worksite program into the organization's structure;
- (4) related programs, such as employee assistance programs; and
- (5) screening programs, preferably linked to medical care delivery to ensure follow-up and appropriate treatment as necessary and to encourage adherence.

This objective is adapted from a measure in Healthy People 2000 objective 8.6, which tracked worksites with less than 50 employees, 50 or more employees, as well as medium and large companies. It measured the proportion that offered any health promotion activity for their employees, preferably as part of a comprehensive employee health promotion program. This measure tracks the proportion of worksites with less than 50, 50 to 99, 100-249, 250 to 749, and 750 or more employees who offer a comprehensive (as defined above) health promotion program to both full- and part-time employees.

See Part C for a description of NWHPS and Appendix A for focus area contact information.



7-5b. Worksites with 50 or more employees.

National Data Source	1999 National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP).
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 8.6 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	34 (1999).
Numerator	Number of worksites with 50 or more employees that offer a comprehensive health promotion program.
Denominator	Number of worksites with 50 or more employees.
Questions Used To Obtain the National Data	From the 1999 National Worksite Health Promotion Survey:

[NUMERATOR:]

[Component 1: Health Education]

- *During the last 12 months, did you offer (Insert Program Type) to your employees at the worksite?*
 - (a) *Physical activity and/or fitness programs or activities*
 - (b) *Nutrition or cholesterol education*
 - (c) *Weight management classes or counseling*
 - (d) *Smoking management classes or counseling*
 - (e) *Stress management classes or counseling*
 - (f) *Alcohol or drug abuse support programs*
 - (g) *Back injury prevention programs*
 - (h) *Maternal or prenatal programs*
 - (i) *Education on balancing work and family*
 - (j) *HIV or AIDS education*
 - (k) *Workplace violence prevention programs*
- *Did your worksite offer Health Awareness Information such as lectures or informational brochures about smoking or other health issues during the last 12 months?*
- *Did your worksite offer Lifestyle Behavior Change Programs such as ongoing meetings, sessions or counseling for weight management or to quit smoking during the last 12 months?*

- *Do you currently offer (Insert Program/service) either through the company, through one or more employee health plans, or not at all?*
 - (a) *Self Care Books or Tools*
 - (b) *Nurse Advice Lines*
 - (c) *Diabetes Management Programs*
 - (d) *Asthma Management Programs*
 - (e) *Cancer Management Programs*
 - (f) *Depression Management Programs*
 - (g) *Hypertension Management Programs*
 - (h) *Cardiovascular Management Programs*
 - (i) *Obesity Management Programs*

[Component 2: Supportive Social and Physical Work Environment]

- *Do you have a formal policy for tobacco that prohibits or severely restricts smoking at the worksite/on the job?*
 - *Do you have a formal policy for alcohol, specifically addressing employee use of alcohol at the worksite/on the job?*
 - *Do you have a formal policy for drugs, specifically addressing employee use of illegal drugs at the worksite/on the job?*
 - *Do you have a formal policy for occupational (sic) protection, specifically requiring use of seat belts during business travel in an automobile?*
 - *Are financial incentives used to encourage program participation in health promotion? How is your (Insert Program Type) program funded? Is it...*
 - 1. *Company paid*
 - 2. *Employee paid*
 - 3. *Shared cost*
- PROGRAM TYPE:*
- a. *Health Screening*
 - b. *Health Risk Assessment*
 - c. *Health Awareness Information*
 - d. *Lifestyle Behavior Change*
- *Does your worksite have an on-site exercise facility?*

[Component 3: Integration of the Worksite Program into the Organization's Administrative Structure]

- *Does your worksite have at least one part-time person responsible for Health Promotion or Worksite Wellness?*
- *Is the improvement of the health status of employees a stated mission or goal for your company?*

- *What are the barriers or challenges to your program's success?*
 - (a) *Lack of access to data (medical, Rx claims, disability, HRA).*
 - (b) *Lack of integration with other programs/services.*

[Component 4: Related Programs like Employees Assistance Programs (EAP)]

- *Do you currently offer Nurse Advice Lines either through the company, through one or more employee health plan, or not at all?*

[Component 5: Screening Programs]

- *During the last 12 months, did you offer (Insert Program Type) to your employees at the worksite or through one of your health plans?*
- - (a) *Screenings for high blood pressure*
 - (b) *Screenings for cholesterol level*
 - (c) *Screenings for any form of cancer*
 - (d) *Health Risk Assessment (HRA) - questionnaires about health habits*

[DENOMINATOR:]

- *How many full-time employees are currently employed at this worksite? These are employees who are continuously employed by this particular worksite, not the entire organization if it has more than one site?*

Number of full-time employees _____
Number of part-time employees _____

Expected Periodicity

Periodic.

Comments

A worksite is considered to have a comprehensive health promotion program if it contains all of the following elements:

(1) A positive response to any of the programs/services listed in Component 1 in the questions above; and

(2) A positive response to any of the policies listed in Component 2; and

(3) A positive response to either of the first two questions (person responsible and stated mission), or a lack of a positive response to the third question (barriers/challenges) listed in Component 3; and

(4) A positive response to the Nurse Advice lines question in Component 4; and

(5) A positive response to any of the screening programs listed in Component 5 in the questions above.

Both full- and part-time employees are included for determining worksite size. The sum of full- and part-time employees must be greater than 49 employees.

This objective is adapted from a measure in Healthy People 2000 objective 8.6, which tracked worksites with less than 50 employees, 50 or more employees, as well as medium and large companies. It measured the proportion that offered any health promotion activity for their employees, preferably as part of a comprehensive employee health promotion program. This measure tracks the proportion of worksites with less than 50, 50 to 99, 100-249, 250 to 749, and 750 or more employees who offer a comprehensive (as defined above) health promotion program to both full- and part-time employees.

See Part C for a description of NWHPS and Appendix A for focus area contact information.



7-5c. Worksites with 50 to 99 employees.

National Data Source	1999 National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP).
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 8.6 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	33 (1999).
Numerator	Number of worksites with 50 to 99 employees that offer a comprehensive health promotion program.
Denominator	Number of worksites with 50 to 99 employees.

Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-5b.
Expected Periodicity	Periodic.
Comments	See Comments provided with 7-5b for more information.



7-5d. Worksites with 100 to 249 employees.

National Data Source	1999 National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP).
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 8.6 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	33 (1999).
Numerator	Number of worksites with 100 to 249 employees that offer a comprehensive health promotion program.
Denominator	Number of worksites with 100 to 249 employees.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-5b.
Expected Periodicity	Periodic.
Comments	See Comments provided with 7-5b for more information.



7-5e. Worksites with 250 to 749 employees.

National Data Source	1999 National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP).
State Data Source	Not identified.

Healthy People 2000 Objective	Adapted from 8.6 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	38 (1999).
Numerator	Number of worksites with 250 to 749 employees that offer a comprehensive health promotion program.
Denominator	Number of worksites with 250 to 749 employees.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-5b.
Expected Periodicity	Periodic.
Comments	See Comments provided with 7-5b for more information.



7-5f. Worksites with 750 or more employees.

National Data Source	1999 National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP).
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 8.6 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	50 (1999).
Numerator	Number of worksites with 750 or more employees that offer a comprehensive health promotion program.
Denominator	Number of worksites with 750 or more employees.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-5b.
Expected Periodicity	Periodic.
Comments	See Comments provided with 7-5b for more information.

7-6. Increase the proportion of employees who participate in employer-sponsored health promotion activities.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 8.7 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	61 (1994).
Numerator	Number of persons 18 years and older who reported that they participated in either quit smoking programs, screening tests, used exercise facilities, or received educational information sponsored by their employer.
Denominator	Number of persons aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1994 National Health Interview Survey:</p> <p>[NUMERATOR:]</p> <ul style="list-style-type: none">➤ <i>In the past year, have you participated in a quit smoking program made available by your employer?</i>➤ <i>In the past year, which of these facilities did you use?</i><ul style="list-style-type: none">(a) <i>Gymnasium/Exercise room</i>(b) <i>Weight lifting equipment</i>(c) <i>Exercise equipment</i>(d) <i>Walking/jogging path</i>(e) <i>Parcourse/Fitness trail</i>(f) <i>Bike path</i>(g) <i>Bike racks</i>(h) <i>Swimming pools</i>(i) <i>Showers</i>(j) <i>Lockers</i>(k) <i>Other - specify</i>

- *In the past year, which of these programs did you participate in?*
 - (a) *Walking group*
 - (b) *Jogging/Running group*
 - (c) *Biking/Cycling group*
 - (d) *Aerobic class*
 - (e) *Swimming class*
 - (f) *Non-aerobic exercise class*
 - (g) *Weight lifting class*
 - (h) *Fully paid membership in health/fitness club*
 - (i) *Partially paid membership in health/fitness club*
 - (j) *Physical activity or exercise competition*
 - (k) *Other - specify*
- *In the past year, did you receive a screening test at your workplace for –*
 - 1) *Blood pressure?*
 - 2) *Cholesterol?*
 - 3) *Cancer?*
- *In the past 12 months, which programs did you participate in at your workplace?*
 - (a) *Weight control*
 - (b) *Nutrition information*
 - (c) *Prenatal education*
 - (d) *Stress reduction and management*
 - (e) *Alcohol and other drugs*
 - (f) *Sexually transmitted diseases (including HIV or AIDS)*
 - (g) *Job hazards and injury prevention*
 - (h) *Back care and prevention of back injury*
 - (i) *Preventing off-the-job accidents*
 - (j) *Other - specify*

[DENOMINATOR:]

- *Were you employed at a job or business during the past two weeks?*
- *Does your employer have 50 or more employees at the building or location where you work?*

Expected Periodicity

Periodic.

Comments

Persons are considered to have participated in employer-sponsored health promotion programs if they responded "yes" any of the services or programs listed in the questions above.

Persons are considered to be employed if they reported they were employed in the past 2 weeks at a job with 50 or more employees.

This objective is adapted from Healthy People 2000 objective 8.7, which tracked the proportion of hourly workers who participated regularly in employer-sponsored quit smoking programs, screening tests, who used exercise facilities, or received educational information. This measure tracks the proportion of all employees, in all occupations, who participated in employer-sponsored quit smoking programs, screening tests, who used exercise facilities and received educational information.

See Part C for a description of NHIS and Appendix A for focus area contact information.



Health Care Setting

7-7. (Developmental) Increase the proportion of health care organizations that provide patient and family education.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Health care organizations refer to organizations that provide health care services. The specific standards for the education provided include:

- (a) Assessment considers cultural and language barriers and desire to learn
- (b) Safe and effective use of medication
- (c) Safe and effective use of medical equipment
- (d) Potential drug-food interactions
- (e) Rehabilitation techniques
- (f) Access to additional resources in the community
- (g) Further treatment
- (h) Discharge instructions
- (i) Educational resources

Patient education is defined as a series of structured or nonstructured experiences which are designed to assist patients to cope voluntarily with the immediate crisis response to their diagnosis, with long-term adjustments, and with symptoms; gain needed skills, knowledge, and attitudes to maintain or regain health status.

This objective is adapted from a measure in Healthy People 2000 objective 8.12, which tracked the proportion of hospitals, health maintenance organizations, and large group practices that provide patient education programs, and the proportion of community hospitals that offer community health programs addressing the priority health needs of their communities. This measure will track the proportion of hospitals, health maintenance organizations, and large group practices that provide both patient and family education programs.

See Appendix A for focus area contact information.



7-8. (Developmental) Increase the proportion of patients who report that they are satisfied with the patient education they receive from their health care organization.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the Press Ganey.

Patient education is defined as a series of structured or nonstructured experiences which are designed to assist patients to cope voluntarily with the immediate crisis response to their diagnosis, with long-term adjustments, and with symptoms; gain needed skills, knowledge, and attitudes to maintain or regain health status.

See Appendix A for focus area contact information.



7-9. (Developmental) Increase the proportion of hospitals and managed care organizations that provide community disease prevention and health promotion activities that address the priority health needs identified by their community.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the American Hospital Association Survey. This annual survey does not include managed care organizations (MCOs), which are systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish health care services to members.

Proposed questions from the American Hospital Association Survey to be used to obtain the data are:

- *Does the hospital's mission statement include a focus on community benefit?*
- *Does the hospital have a long-term plan for improving the health of its community?*
- *Does the hospital have resources for its community benefits activities?*
- *Does the hospital work with other local providers, public agencies or community representatives to conduct a health status assessment of the community?*
- *Does the hospital work with other local providers, public agencies or community representatives to develop a written assessment of the appropriate capacity for health services in the community?*

[If yes:]

- *Has the hospital used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community?*

This objective is adapted from a measure in Healthy People 2000 objective number 8.12, which tracked the proportion of community hospitals that offer community health programs addressing the priority health needs of their communities. This measure will track the proportion of community hospitals, as well as managed care organizations, that provide community disease prevention and health promotion activities that address the priority health needs identified by their communities.

Managed care includes health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans.

See Appendix A for focus area contact information.



Community Setting and Special Populations

- 7-10. (Developmental) Increase the proportion of Tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas.**

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is a survey to be developed and administered by Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPE).

The proposed measure is the proportion of local health service areas or jurisdictions, identified by ASTDHPPHE representatives in each State, the District of Columbia, the Territories (American Samoa, Guam, Puerto Rico, and Virgin Islands), and Regional Indian Health Service offices that have health promotion initiatives existing in the identified local health service areas or jurisdictions.

Local health service areas refers to local health jurisdictions and local health serving unit catchment areas.

Community health promotion initiative includes all of the following:

- (1) Community participation with representatives from at least three of the following community sectors: government, education, business, faith organizations, health care, media, voluntary agencies, and the public;
- (2) Community assessment, guided by a community assessment and planning model (such as APEX/PH; Healthy Cities, Healthy Communities; PATCH; or other comprehensive model), to determine community health problems, resources, perceptions, and priorities for action;
- (3) Targeted and measurable objectives to address at least one of the following: health concerns, risk factors, public awareness, services, and protection;
- (4) Comprehensive multifaceted, culturally relevant interventions that have multiple targets for change (individuals, organizations, and environments) and multiple approaches to change, including education, community organization, and regulatory and environmental reforms; and
- (5) Monitoring and evaluation processes to determine whether the objectives are reached.

This objective was adapted from Healthy People 2000 objective 8.10, which tracked the establishment of community health promotion programs that separately or together address at least 3 of the Healthy People 2000 priority areas. This measure will track the proportion of Tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 health focus areas.

See Appendix A for focus area contact information.



7-11. Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

7-11a. (Developmental) Access to quality health services.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate community health promotion programs for clinical preventive services for racial and ethnic minority populations. This measure will track the proportion of local health departments that have culturally appropriate and linguistically competent community health promotion programs that address access to quality health services racial and ethnic minority populations.

Data from the 1996–97 National Profile of Local Health Departments on clinical preventive services are presented for illustrative purposes for the access to quality health services measure.

See Part C for a description of NPLHD and Appendix A for focus area contact information.

7-11b. (Developmental) Arthritis, osteoporosis, and chronic back conditions.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate community health promotion programs for diabetes and other chronic disabling conditions, which included arthritis, osteoporosis, and chronic back conditions as a component, for racial and ethnic minority populations.

This measure will only track the proportion of local health departments that have culturally appropriate and linguistically competent community arthritis, osteoporosis, and chronic back conditions programs for racial and ethnic minority populations.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11c. Cancer.

National Data Source

National Profile of Local Health Departments, NACCHO.

State Data Source

National Profile of Local Health Departments, NACCHO.

Healthy People 2000 Objective

8.11 (Educational and Community-Based Programs).

Measure

Percent.

Baseline

30 (1996–97).

Numerator

Number of local health departments that provided culturally and linguistically appropriate cancer programs to their jurisdiction in the past year.

Denominator

Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.

**Questions Used To
Obtain the National
Data**

From the 1996–97 National Profile of Local
Health Departments:

[NUMERATOR:]

- *In the past year, which of the following programs and interventions were provided in your jurisdiction, either directly by your local health department or through a contractual agreement with another organization?*

[Programs:]

- (a) Physical activities and fitness*
- (b) Nutrition*
- (c) Tobacco*
- (d) Alcohol and other drugs*
- (e) Family Planning*
- (f) Mental health and mental disorders*
- (g) Violent and abusive behavior*
- (h) Educational and community-based programs*
- (i) Unintentional injuries*
- (j) Occupational safety and health*
- (k) Environment health*
- (l) Food and drug safety*
- (m) Oral health*
- (n) Maternal and infant health*
- (o) Heart disease and stroke*
- (p) Cancer*
- (q) Diabetes and chronic disabling conditions*
- (r) HIV infections*
- (s) Sexually transmitted diseases*
- (t) Immunization and infectious diseases*
- (u) Clinical preventive services*
- (v) Surveillance and data systems*
- (w) Other (specify) _____*

[Interventions:]

Informational Materials

- (a) Print*
- (b) Audiovisual*

Public Service Announcement

- (a) Radio*
- (b) Television*

Internet

Community Outreach

On-site

- (a) Individual Instruction*
- (b) Group Instruction*
- Other (specify) _____*

- *In the past year, which of the following programs and interventions listed above were adapted and/or provided to meet the special language needs of any racial/minority group you serve, either directly by your local health department or through a contractual agreement with another organization?*
- *In the past year, which of the following programs and interventions listed above were adapted and/or provided to address the cultural differences of any racial/minority population you serve, either directly by your local health department or through a contractual agreement with another organization?*

[DENOMINATOR:]

- *Please indicate the percentages of the racial composition of your jurisdiction.*
 - (a) *Asian or pacific Islander*
 - (b) *American Indian, Alaska native or Aleut*
 - (c) *Black*
 - (d) *White*
 - (e) *Other*
- *Please indicate the percentages of the ethnic composition of your jurisdiction.*
 - (a) *Hispanic origin*
 - (b) *Not of Hispanic origin*
 - (c) *Unknown*

Expected Periodicity

Periodic.

Comments

A local health department is classified as having a culturally appropriate and linguistically competent community program in the specific health area targeted by the objective if it indicated that in the past year:

- (1) it provided programs or interventions in the specific health area targeted by the objective (in the first question above);
- (2) the programs were adapted and/or provided to meet special language needs of racial/ethnic minorities (in the second question above); and,
- (3) the programs were adapted and/or provided to address cultural differences of racial/ethnic minorities (in the third question above).

Local health departments eligible for inclusion in this objective are those for which either the American Indian/Alaska Native, Asian/Pacific Islander, black/African American, or Hispanic populations comprise at least 10 percent of the total population in their jurisdiction.

This objective currently is being tracked in local health departments in which a racial or ethnic group constitutes at least 10 percent of the population. In future studies, by utilizing census data, local health departments that serve communities in which at least 3,000 people in the county indicate that their primary language is other than English or a similar population meets the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes also should be measured.

Culturally appropriate refers to an unbiased attitude and organizational policy that values cultural diversity in the population served; reflects an understanding of diverse attitudes, beliefs, behaviors, practices, and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age, gender, sexual orientation, or generations and acculturation status; an awareness that cultural differences may affect health and the effectiveness of health care delivery; and knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, disability, or habits.

Linguistically competent refers to skills to communicate effectively in the native language or dialect of the targeted population, taking into account general educational level, literacy, and language preferences.

In 1996–97, 151 local health departments reported that a program or intervention in the area of cancer was provided to its jurisdiction.

See Part C for a description of NPLHD and Appendix A for focus area contact information.

7-11d. (Developmental) Chronic kidney disease.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate diabetes and other chronic disabling conditions community health promotion programs for racial and ethnic minority populations. This measure includes only the proportion of local health departments that have culturally appropriate and linguistically competent community chronic kidney disease programs for racial and ethnic minority populations.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11e. (Developmental) Diabetes.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate diabetes and other chronic disabling conditions community health promotion programs for racial and ethnic minority populations.

This measure includes only the proportion of local health departments that have culturally appropriate and linguistically competent community diabetes programs for racial and ethnic minority populations.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11f. (Developmental) Disability and secondary conditions.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate diabetes and other chronic disabling conditions community health promotion programs for racial and ethnic minority populations. This measure includes only the proportion of local health departments that have culturally appropriate and linguistically competent community disability and secondary conditions programs for racial and ethnic minority populations.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11g. Educational and community-based programs.

National Data Source

National Profile of Local Health Departments, NACCHO.

State Data Source

National Profile of Local Health Departments, NACCHO.

Healthy People 2000 Objective

8.11 (Educational and Community-Based Programs).

Measure

Percent.

Baseline

33 (1996-97).

Numerator

Number of local health departments that provided culturally and linguistically appropriate education and community-based programs to their jurisdiction in the past year.

Denominator

Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.

Questions Used To Obtain the National Data

See Questions Used To Obtain the National Data provided with 7-11c.

Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 127 local health departments reported that a program or intervention in the area of education and community-based programs was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>



7-11h. Environmental health.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	22 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate environmental health programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.

In 1996–97, 149 local health departments reported that a program or intervention in the area of environmental health was provided to its jurisdiction.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11i. Family planning.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	42 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate family planning programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 158 local health departments reported that a program or intervention in the area of family planning was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>

7-11j. (Developmental) Food safety.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate food and drug safety community health promotion programs for racial and ethnic minority populations. This measure includes only the proportion of local health departments that have culturally appropriate and linguistically competent community food safety programs for racial and ethnic minority populations.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11k. (Developmental) Medical product safety.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate food and drug safety community health promotion programs for racial and ethnic minority populations.

This measure includes only the proportion of local health departments that have culturally appropriate and linguistically competent community medical product safety programs for racial and ethnic minority populations.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11l. (Developmental) Health communication.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. This measure will track the proportion of local health departments that have culturally appropriate and linguistically competent community health communication programs for racial and ethnic minority populations.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>
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7-11m. Heart disease and stroke.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	28 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate heart disease and stroke programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11a.
Expected Periodicity	Periodic.

Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 148 local health departments reported that a program or intervention in the area of heart disease and stroke was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>
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7-11n. HIV.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	45 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate HIV programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 170 local health departments reported that a program or intervention in the area of HIV was provided to its jurisdiction.</p>

See Part C for a description of NPLHD and
Appendix A for focus area contact information.



7-11o. Immunizations and infectious diseases.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	48 (1996–97).
Numerator	Number of local health departments with that provided culturally and linguistically appropriate immunizations and infectious disease programs to their jurisdiction.
Denominator	Number of local health departments with at least 10 percent racial/ethnic population groups in their jurisdiction that offered immunizations and infectious disease programs.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 183 local health departments reported that a program or intervention in the area of immunizations and infectious diseases was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>



7-11p. (Developmental) Injury and violence prevention.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate violent and abusive behavior or unintentional injury community health promotion programs for racial and ethnic minority populations. This measure includes only the proportion of local health departments that have culturally appropriate and linguistically competent community injury and violence prevention programs for racial and ethnic minority populations.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11q. Maternal, infant (and child) health.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	Adapted from 8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	47 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate maternal, infant and child health programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.

Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate maternal and infant health community health promotion programs for racial and ethnic minority populations. This measure tracks the proportion of local health departments that have culturally appropriate and linguistically competent community maternal, infant and child health programs for racial and ethnic minority populations.</p> <p>In 1996–97, 174 local health departments reported that a program or intervention in the area of maternal and infant health was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>



7-11r. Mental health (and mental disorders).

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	18 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate mental health and mental disorders programs to their jurisdiction in the past year.

Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 76 local health departments reported that a program or intervention in the area of mental health and mental disorders was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>



7-11s. Nutrition and overweight.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	Adapted from 8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	44 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate nutrition and overweight programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.

Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. This measure tracks the proportion of local health departments that have culturally appropriate and linguistically competent nutrition and overweight programs for racial and ethnic minority populations.</p> <p>In 1996–97, 168 local health departments reported that a program or intervention in the area of nutrition and overweight was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>



7-11t. Occupational safety and health.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	13 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate occupational safety and health programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.

Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 84 local health departments reported that a program or intervention in the area of occupational safety and health was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>



7-11u. Oral health.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	25 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate oral health programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.

Comments	<p>See the definition of racial/ethnic composition, culturally appropriate and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 126 local health departments reported that a program or intervention in the area of oral health was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>
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7-11v. Physical activity and fitness.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	21 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate physical activity and fitness programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 111 local health departments reported that a program or intervention in the area of physical activity and fitness was provided to its jurisdiction.</p>

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11w. (Developmental) Public health infrastructure.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate data and surveillance community health promotion programs for racial and ethnic minority populations. This measure tracks the proportion of local health departments that have culturally appropriate and linguistically competent public health infrastructure programs for racial and ethnic minority populations.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



7-11x. (Developmental) Respiratory diseases.

Comments

An operational definition could not be specified at the time of publication.

This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate community health promotion tobacco, environmental health or diabetes and other chronic disabling conditions programs, which included respiratory diseases as a component, for racial and ethnic minority populations. This measure will only track the proportion of local health departments that have culturally appropriate and linguistically competent community respiratory diseases programs for racial and ethnic minority populations.

See Part C for a description of NPLHD and
Appendix A for focus area contact information.



7-11y. Sexually transmitted diseases.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	41 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate sexually transmitted diseases programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 172 local health departments reported that a program or intervention in the area of sexually transmitted diseases was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>



7-11z. Substance abuse (alcohol and other drugs).

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	Adapted from 8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	26 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate substance abuse of alcohol and other drugs programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate alcohol and other drug community health promotion programs for racial and ethnic minority populations. This measure tracks the proportion of local health departments that have culturally appropriate and linguistically competent substance abuse of alcohol and other drugs programs for racial and ethnic minority populations.</p> <p>In 1996–97, 172 local health departments reported that a program or intervention in the area of substance abuse of alcohol and other drugs was provided to its jurisdiction.</p>

See Part C for a description of NPLHD and
Appendix A for focus area contact information.



7-11aa. Tobacco use.

National Data Source	National Profile of Local Health Departments, NACCHO.
State Data Source	National Profile of Local Health Departments, NACCHO.
Healthy People 2000 Objective	8.11 (Educational and Community-Based Programs).
Measure	Percent.
Baseline	24 (1996–97).
Numerator	Number of local health departments that provided culturally and linguistically appropriate tobacco use programs to their jurisdiction in the past year.
Denominator	Number of local health departments with one or more minority racial/ethnic population groups comprising at least 10 percent of the population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 7-11c.
Expected Periodicity	Periodic.
Comments	<p>See the definition of racial/ethnic composition, culturally appropriate, and linguistically competent provided with 7-11c for more information.</p> <p>In 1996–97, 161 local health departments reported that a program or intervention in the area of tobacco use was provided to its jurisdiction.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>



7-11bb. (Developmental) Vision and hearing.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>This measure is adapted from Healthy People 2000 objective 8.11, which tracked the proportion of local health departments that have established culturally and linguistically appropriate community health promotion programs for diabetes and other chronic disabling conditions, which included vision and hearing as a component, for racial and ethnic minority populations. This measure will only track the proportion of local health departments that have culturally appropriate and linguistically competent vision and hearing programs for racial and ethnic minority populations.</p> <p>See Part C for a description of NPLHD and Appendix A for focus area contact information.</p>
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7-12. Increase the proportion of older adults who have participated during the preceding year in at least one organized health promotion activity.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	8.8 (Educational and Community-Based Programs).
Measure	Percent (age adjusted—see Comments).
Baseline	12 (1998).
Numerator	Number of older adults aged 65 years and older who participated in an exercise class/program or attended a class/presentation on health topics in the past 12 months.
Denominator	Number of older adults aged 65 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data

From the 1998 National Health Interview Survey:

- *In the past 12 months, have you taken a class or attended a presentation on health topics?*
- *In the past 12 months, did you participate in an exercise class or exercise program?*

Expected Periodicity

Periodic.

Comments

Adults 65 years and older are considered to have participated in an organized health promotion activity if they report that had taken a class or attended a presentation on health topics, or had participated in an exercise class or program in the past year.

An program is any health class, presentation on a health-related topic, exercise class, or exercise program.

Data are age adjusted to the 2000 standard population. Age-adjusted percentages are weighted sums of age-specific percentages. For discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and Appendix A for focus area contact information.



Reference

1. U.S. Department of Health and Human Services. *1992 National Survey of Worksite Health Promotion Activities Summary Report*. Washington, DC: U.S. Government Printing Office, 1993.

8

Environmental Health

Outdoor Air Quality

- 8-1 Harmful air pollutants
 - 8-1a Ozone
 - 8-1b Particulate matter
 - 8-1c Carbon monoxide
 - 8-1d Nitrogen dioxide
 - 8-1e Sulfur dioxide
 - 8-1f Lead
 - 8-1g Total number of people
- 8-2 Alternative modes of transportation
 - 8-2a Trips made by bicycling
 - 8-2b Trips made by walking
 - 8-2c Trips made by transit
 - 8-2d Persons who telecommute
- 8-3 Cleaner alternative fuels
- 8-4 Airborne toxins

Water Quality

- 8-5 Safe drinking water
- 8-6 Waterborne disease outbreaks
- 8-7 Water conservation
- 8-8 Surface water health risks
- 8-9 Beach closings
- 8-10 Fish contamination

Toxics and Waste

- 8-11 Elevated blood lead levels in children
- 8-12 Risks posed by hazardous sites

- 8-12a National Priority List sites
- 8-12b Resource Conservation and Recovery Act facilities
- 8-12c Leaking underground storage facilities
- 8-12d Brownfield properties
- 8-13 Pesticide exposures
- 8-14 Toxic pollutants
- 8-15 Recycled municipal solid waste

Healthy Homes and Healthy Communities

- 8-16 Indoor allergens
 - 8-16a Dust mite allergens that exceed 2 μ g/gram
 - 8-16b Dust mite allergens that exceed 10 μ g/gram
 - 8-16c German cockroach allergens
- 8-17 Office building air quality
- 8-18 Homes tested for radon
- 8-19 Radon-resistant new home construction
- 8-20 School policies to protect against environmental hazards
- 8-21 Disaster preparedness plans and protocols
- 8-22 Lead-based paint testing
- 8-23 Substandard housing

Infrastructure and Surveillance

- 8-24 Exposure to pesticides
 - 8-24a 1-naphthol
 - 8-24b Paranitrophenol
 - 8-24c 3,5,6-trichloro-2-pyridinol
 - 8-24d Isopropoxyphenol
- 8-25 Exposure to heavy metals and other toxic chemicals
 - 8-25a Arsenic
 - 8-25b Cadmium
 - 8-25c Lead
 - 8-25d Manganese
 - 8-25e Mercury
 - 8-25f 2,4-D
 - 8-25g o-phenylphenol
 - 8-25h Permethrins
 - 8-25i Diazinon
 - 8-25j Polychlorinated biphenyls
 - 8-25k Dioxins
 - 8-25l Furans
 - 8-25m Chlordan

- 8-25n Dieldrin
- 8-25o DDT
- 8-25p Lindane
- 8-26 Information systems used for environmental health
- 8-27 Monitoring environmentally related diseases
 - 8-27a Lead poisoning
 - 8-27b Pesticide poisoning
 - 8-27c Mercury poisoning
 - 8-27d Arsenic poisoning
 - 8-27e Cadmium poisoning
 - 8-27f Methemoglobinemia
 - 8-27g Acute chemical poisoning
 - 8-27h Carbon monoxide poisoning
 - 8-27i Asthma
 - 8-27j Hyperthermia
 - 8-27k Hypothermia
 - 8-27l Skin cancer
 - 8-27m Malignant melanoma
 - 8-27n Other skin cancer
 - 8-27o Birth defects
- 8-28 Local agencies using surveillance data for vector control

Global Environmental Health

- 8-29 Global burden of disease
- 8-30 Water quality in the United States-Mexico border region
 - Wastewater sewer service:
 - 8-30a Ciudad Acuna
 - 8-30b Matamoros
 - 8-30c Mexicali
 - 8-30d Nogales, Sonora
 - 8-30e Piedras Negras
 - 8-30f Reynosa
 - Wastewater receiving treatment:
 - 8-30g Ciudad Acuna
 - 8-30h Matamoros
 - 8-30i Mexicali
 - 8-30j Nogales, Sonora
 - 8-30k Piedras Negras
 - 8-30l Reynosa

Outdoor Air Quality

8-1. Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for harmful air pollutants.

8-1a. Ozone.

National Data Source	Aerometric Information Retrieval System, EPA, OAR.
State Data Source	Aerometric Information Retrieval System, EPA, OAR.
Leading Health Indicator	Environmental Quality.
Healthy People 2000 Objective	Adapted from 11.5 (Environmental Health).
Measure	Percent.
Baseline	43 (1997).
Numerator	Number of persons living in nonattainment areas that exceed the National Ambient Air Quality Standards for ozone in 1997.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	All areas (100 percent) are required by law to come into attainment no later than 2012 for all pollutant criteria except particulate matter 2.5, which will come into attainment by 2017. EPA's air quality monitoring and NAAQS data collection have historically taken place in large urban centers and other appropriate areas generally considered to have the Nation's poorest air quality.

Nonattainment areas may include single counties, multiple counties, parts of counties, municipalities, or combinations of the preceding jurisdictions. When an area is designated as "nonattainment," it retains this status for 3 years, regardless of annual changes in air quality. Nonattainment areas may also include jurisdictions in which the source of the pollutants are located, even if that jurisdiction meets all NAAQS.

The areas monitored may change over time to reflect changes in air quality or the pollutants being monitored.

The population estimates used for the baseline are based on 1990 census estimates and do not reflect growth or depletion of population since that date. The NAAQS were revised in 1997 by EPA, but the revisions are currently being contested in court; resolution of the court case may affect the population estimates in the baseline.

The use of nonattainment areas in this objective represents an important measurement distinction from the measure used in Healthy People 2000 objective 11.5, which used counties that did not meet NAAQS in the previous 12 months. Nonattainment areas may include counties that did not meet NAAQS, but also counties that met the standards, but are sources of the pollutants.

This objective is one of the measures used to track the Environmental Quality Leading Health Indicator. See Appendix H for a complete list.

See Appendix A for focus area contact information.



8-1b. Particulate matter.

National Data Source	Aerometric Information Retrieval System, EPA, OAR.
State Data Source	Aerometric Information Retrieval System, EPA, OAR.
Healthy People 2000 Objective	Adapted from 11.5 (Environmental Health).
Measure	Percent.

Baseline	12 (1997).
Numerator	Number of persons living in nonattainment areas that exceed the National Ambient Air Quality Standards for particulate matter in 1997.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 8-1a for more information.



8-1c. Carbon monoxide.

National Data Source	Aerometric Information Retrieval System, EPA, OAR.
State Data Source	Aerometric Information Retrieval System, EPA, OAR.
Healthy People 2000 Objective	Adapted from 11.5 (Environmental Health).
Measure	Percent.
Baseline	19 (1997).
Numerator	Number of persons living in nonattainment areas that exceed the National Ambient Air Quality Standards for carbon monoxide in 1997.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 8-1a for more information.



8-1d. Nitrogen dioxide.

National Data Source	Aerometric Information Retrieval System, EPA, OAR.
State Data Source	Aerometric Information Retrieval System, EPA, OAR.
Healthy People 2000 Objective	Adapted from 11.5 (Environmental Health).
Measure	Percent.
Baseline	5 (1997).
Numerator	Number of persons living in nonattainment areas that exceed the National Ambient Air Quality Standards for nitrogen dioxide in 1997.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 8-1a for more information.



8-1e. Sulfur dioxide.

National Data Source	Aerometric Information Retrieval System, EPA, OAR.
State Data Source	Aerometric Information Retrieval System, EPA, OAR.
Healthy People 2000 Objective	Adapted from 11.5 (Environmental Health).
Measure	Percent.
Baseline	2 (1997).
Numerator	Number of persons living in nonattainment areas that exceed the National Ambient Air Quality Standards for sulfur dioxide in 1997.

Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 8-1a for more information.



8-1f. Lead.

National Data Source	Aerometric Information Retrieval System, EPA, OAR.
State Data Source	Aerometric Information Retrieval System, EPA, OAR.
Healthy People 2000 Objective	Adapted from 11.5 (Environmental Health).
Measure	Percent.
Baseline	<1 (1997).
Numerator	Number of persons living in nonattainment areas that exceed the National Ambient Air Quality Standards for lead in 1997.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 8-1a for more information.



8-1g. Total number of people.

National Data Source	Aerometric Information Retrieval System, EPA, OAR.
State Data Source	Aerometric Information Retrieval System, EPA, OAR.
Healthy People 2000 Objective	Adapted from 11.5 (Environmental Health).
Measure	Number.
Baseline	119,803,000 (1997).
Numerator	Number of persons living in areas that exceed the National Ambient Air Quality Standards (nonattainment areas) for either ozone, carbon monoxide, nitrogen dioxide, sulfur dioxide, particulate matter 10 or 2.5, or lead.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 8-1a for more information.



8-2. Increase use of alternative modes of transportation to reduce motor vehicle emissions and improve the Nation's air quality.

8-2a. Trips made by bicycling.

National Data Sources	National Center for Bicycling and Walking; Nationwide Personal Transportation Survey (NPTS), DOT, FHWA.
State Data Source	Nationwide Personal Transportation Survey (NPTS), DOT, FHWA.
Healthy People 2000 Objective	Not applicable.

Measure	Percent.
Baseline	0.9 (1995).
Numerator	Number of trips taken by bicycling.
Denominator	Total number of trips.
Population Targeted	U.S. civilian noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1995 Nationwide Personal Transportation Survey:

Now I have some questions about all trips (you/Person) took (yesterday/on Travel Day), (including long trips that may have already been reported). For these questions, a "trip" is any time (you/Person) went from one address to another by car, bus, walking, bicycling, or some other means. For example, if you leave work, stop at the store, and then continue home that would be two trips C one to the store and one from the store to home.

- *Did (you/Person) go anywhere (yesterday/on Travel Day)?*

(Excluding the trips taken as a regular part of the job), please tell me everywhere (you/Person) went (yesterday/on Travel Day). Remember, we want to know about any time (you/Person) went from one place to another for any purpose.

- *Where did (you/Person) go first (yesterday/on Travel Day)?*
- *When (you/Person) left (Destination) where did (you/Person) go next?*

Repeat question until no more trips....

For nonsegmented trips:

- *How did (you/Person) get to (Destination)? That is, what means of transportation did (you/Person) use for this trip?*

<i>Bicycle</i>	<i>Bus</i>
<i>Elevated rail</i>	<i>Subway</i>
<i>Walking</i>	<i>Streetcar or trolley</i>
<i>Commuter rail</i>	

For multisegment trips:

- *What means of transportation did (you/Person) use for the (first/next) part of this trip to (Destination)?*

<i>Bicycle</i>	<i>Bus</i>
<i>Elevated rail</i>	<i>Subway</i>
<i>Walking</i>	<i>Streetcar or trolley</i>
<i>Commuter rail</i>	

Continue for additional segments...

Expected Periodicity

Periodic.

Comments

The number of trips is the sum of nonsegment trips plus each part of a multisegment trip. The 1995 NPTS characterizes a "trip" as travel to a destination (for example, worksite). Travel to work, for instance, that includes two stops along the way (trip chains) would constitute three trips.

NPTS is a household survey that uses resident logs of their trips; data are collected every 5 years. The 1995 NPTS sample design provided a scientific sample of households with telephones in the United States, covering all 50 States and the District of Columbia. The sample was stratified by geography and time so that the data collection would be dispersed nearly uniformly throughout the country and across the data collection period. The sampling was also controlled by day of week to capture variations in personal travel within a week. A Mitofsky-Waksberg random-digit-dialing design was used to select the sample telephone numbers, both listed and unlisted.

Demographic data for each household member included age, sex, and race of the household reference person (person who owned or rented the home), and the relationship of each household member to the reference person, annual combined household income, and education. The travel day was defined as beginning at 4:00 a.m. on the designated day and ending at 3:59 a.m. on the following day.

The data for this objective are different from those for objective 22-15 in the Physical Activity and Fitness focus area because the Physical Activity and Fitness objective specifies distance and age; the data presented for this objective do not include these restrictions.

See Appendix A for focus area contact information.



8-2b. Trips made by walking.

National Data Sources	National Center for Bicycling and Walking; Nationwide Personal Transportation Survey (NPTS), DOT, FHWA.
State Data Source	Nationwide Personal Transportation Survey (NPTS), DOT, FHWA.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	5.4 (1995).
Numerator	Number of trips taken by walking.
Denominator	Total number of trips.
Population Targeted	U.S. civilian noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 8-2a.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-2a for more information.



8-2c. Trips made by transit.

National Data Sources	National Center for Bicycling and Walking; Nationwide Personal Transportation Survey (NPTS), DOT, FHWA.
State Data Source	Nationwide Personal Transportation Survey (NPTS), DOT, FHWA.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	1.8 (1995).
Numerator	Number of trips taken by transit.
Denominator	Total number of trips.
Population Targeted	U.S. civilian noninstitutionalized population.

Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 8-2a.
Expected Periodicity	Periodic.
Comments	Transit is defined as having used bus, elevated rail, subway, commuter rail, or streetcar or trolley. See Comments provided with objective 8-2a for more information.



8-2d. (Developmental) Persons who telecommute.

Comments	An operational definition could not be specified at the time of publication. The proposed data source for people who telecommute will be available from the Federal Highway Administration through 2010. See Appendix A for focus area contact information.
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8-3. Improve the Nation's air quality by increasing the use of cleaner alternative fuels.

National Data Source	Alternatives to Traditional Transportation Fuels, Energy Information Administration, DOE.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	2.7 (1997).
Numerator	U.S. motor fuel consumption of cleaner alternative fuels by privately owned cars, buses, trucks, and vans (see Comments).
Denominator	Total U.S. fuel consumption.
Questions Used To Obtain the National Data	From the 1998 Alternatives to Traditional Transportation Fuels:

➤ *Alternative Fuel Vehicle (AFV) numbers*

➤ *How many AFVs did your stakeholders acquire in 1998?*

Light duty CNG _____
Propane (LPG) _____
Electric _____
Biodiesel _____
LNG _____
Methanol _____
Ethanol _____
Other _____

○ *Of the vehicles reported, how many are:*

Taxis? _____
Police cruisers? _____

Heavy duty CNG _____
Propane (LPG) _____
Electric _____
Biodiesel _____
LNG _____
Methanol _____
Ethanol _____
Other _____

➤ *What is the total number of AFVs in your coalition?*

Light duty CNG _____
Propane (LPG) _____
Electric _____
Biodiesel _____
LNG _____
Methanol _____
Ethanol _____
Other _____

○ *Of the vehicles reported, how many are:*

Taxis? _____
Police cruisers? _____

Heavy duty CNG _____
Propane (LPG) _____
Electric _____
Biodiesel _____
LNG _____
Methanol _____
Ethanol _____
Other _____

○ *Of the vehicles reported, how many are:*

School buses? _____
Transit buses? _____

- What do you expect the total number of AFVs in your coalition to be in 2000?

Total _____
 (add your best estimate of the breakout by fuel below)
 Light duty CNG _____
 LNG _____
 Propane (LPG) _____
 Methanol _____
 Electric _____
 Ethanol _____
 Biodiesel _____
 Other _____

 Heavy duty CNG _____
 Propane (LPG) _____
 Electric _____
 Biodiesel _____
 LNG _____
 Methanol _____
 Ethanol _____
 Other _____

Expected Periodicity

Periodic.

Comments

Motor fuel consumption of cleaner alternative fuels is estimated using an established methodology based on the number of alternative-fueled vehicles in use. The number of vehicles is determined from the Alternatives to Traditional Transportation Fuels Survey, conducted annually by the Energy Information Administration, DOE. For more detailed information on the survey and the estimating methodology, see <http://www.eia.gov/fuelalternate.html>.

See Appendix A for focus area contact information.



8-4. Reduce air toxic emissions to decrease the risk of adverse health effects caused by airborne toxics.

National Data Source

National Toxic Release Inventory (TRI), EPA.

State Data Source

Not identified.

Healthy People 2000 Objective

Adapted from 11.7 (Environmental Health).

Measure

Number.

Baseline

8.1 (1993).

Numerator	Millions of tons of toxics released into the air by private industries.
Denominator	Not specified.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The TRI list of airborne toxics that pose the greatest threat to public health is updated annually to reflect new information related to industry airborne emissions and revised assessments of the danger posed by specific substances. To assess progress for this objective, however, the list of airborne toxics monitored will be “frozen” to those included on the 1993 list to ensure comparability of updates during the monitoring period.</p> <p>This objective differs from Healthy People 2000 objective 11-7, which measured carcinogens, compiled by HHS and the most toxic chemicals, compiled by ATSDR, in billions of pounds.</p> <p>See Appendix A for focus area contact information.</p>



Water Quality

8-5. Increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act.

National Data Sources	Potable Water Surveillance System (PWSS) and Safe Drinking Water Information System (SDWIS), EPA.
State Data Source	Local drinking water supplies reports by State.
Healthy People 2000 Objective	Adapted from 11.9 (Environmental Health).
Measure	Percent.
Baseline	85 (1995).

Numerator	Number of persons served by community water supply utilities that do not have violations of the Safe Drinking Water Act Regulation.
Denominator	Number of persons served by community water supplies.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The violations of the Safe Drinking Water Act are limited to those related to the Maximum Contaminant Levels for specific contaminants and do not include violations related to monitoring and reporting requirements. The number of contaminants monitored has changed over time, which affects trends. The denominator is estimated from reports of the number of persons served by the water system providers. While 93 percent of the U.S. population is served by community water supplies, those using wells or other sources are not included in the population estimates reported for this objective.</p> <p>This objective differs from Healthy People 2000 objective 11.9, which included violations related to monitoring and reporting requirements in the numerator.</p> <p>See Appendix A for focus area contact information.</p>



8-6. Reduce waterborne disease outbreaks arising from water intended for drinking among persons served by community water systems.

National Data Source	State Reporting Systems, CDC, NCID.
State Data Source	State health departments.
Healthy People 2000 Objective	11.3 (Environmental Health).
Measure	Number (10-year average).
Baseline	6 (1987–96).

Numerator	Number of outbreaks where two or more people are affected by infectious agents or one or more people are affected by chemical agents from water intended for drinking.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Biennial—see Comments.
Comments	<p>The data include only outbreaks from infectious agents (in two or more persons) and chemical poisoning (in a single person) from water intended for drinking. Community water systems are public or investor-owned water systems that serve large or small communities, subdivisions, or trailer parks with at least 15 service connections or 25 year-round residents.</p> <p>Although the reporting of these data is biennial, they are obtained annually by CDC.</p> <p>See Appendix A for focus area contact information.</p>



8-7. Reduce the per capita domestic water withdrawals.

National Data Source	Estimated Use of Water in the United States, DOI, USGS.
State Data Source	State publications prepared as part of the USGS National Water-Use Information Program, as referenced at http://water.usgs.gov/watuse/pdf1995/pdf/bibliography.pdf .
Healthy People 2000 Objective	Not applicable.
Measure	Rate.
Baseline	101 (1995).
Numerator	Gallons of water used for domestic purposes per day.
Denominator	Number of people.

Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	<p>The data reported reflect domestic water use only and do not include water used in industrial or institutional settings. USGS publishes this information every 5 years. The year 2000 publication should be available in 2003.</p> <p>See Appendix A for focus area contact information.</p>



8-8. (Developmental) Increase the proportion of assessed rivers, lakes, and estuaries that are safe for fishing and recreational purposes.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>The proposed national data source is the revised Clean Water Act Section 305-b report, EPA. These reports build on State data collection, include state breakouts, and thus can serve as the State data source as well. This report should be available in 2001.</p> <p>This objective is adapted from Healthy People 2000 objective 11.10, which provided biennial data (this objective will provide cumulative data). Additionally, data for this objective will be based on different surface water bodies.</p> <p>See Appendix A for focus area contact information.</p>
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8-9. (Developmental) Reduce the number of beach closings that result from the presence of harmful bacteria.

Comments	An operational definition could not be specified at the time of publication.
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The proposed national data source is EPA's compilation of State data on beach closings. The National Resources Defense Fund has done some preliminary analyses using EPA data.

See Appendix A for focus area contact information.



8-10. (Developmental) Reduce the potential human exposure to persistent chemicals by decreasing fish contaminant levels.

Comments An operational definition could not be specified at the time of publication.

The proposed national data source will extrapolate data from the following sources: Biomonitoring of Environmental Status and Trends; collection of mercury and other contaminant data in whole fish in the Mississippi River, Rio Grande River, and Columbia River basins, DOI, USGS and FWS; and State fish consumption advisories. The proposed State data sources are State fish consumption advisories.

See Appendix A for focus area contact information.



Toxics and Waste

8-11. Eliminate elevated blood lead levels in children.

National Data Source	National Health and Nutritional Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 11.4 (Environmental Health).
Measure	Percent.
Baseline	4.4 (1991–94).
Numerator	Number of children aged 1 to 6 years with blood lead levels exceeding 10µg/dL.

Denominator	Number of children aged 1 to 5 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>This objective differs from Healthy People 2000 objective 11.4 in that it targets children aged 1 to 5 years; the baseline for 11.4 targeted children aged 6 months to 5 years. Additionally, 11.4 focused on blood lead levels (BLLs) of 15 and 25µg/dL, and this objective focuses on levels of 10µg/dL. BLLs of at least 10µg/dL are high enough to adversely affect children's intelligence, behavior, and development, hence the revision was prompted by more current knowledge in the field.</p> <p>See Appendix A for focus area contact information.</p>



8-12. Minimize the risks to human health and the environment posed by hazardous sites.

8-12a. National Priority List sites.

National Data Source	Comprehensive Environmental Response and Cleanup Liability Information System (CERCLIS), OSWER, EPA.
State Data Source	Comprehensive Environmental Response and Cleanup Liability Information System (CERCLIS), OSWER, EPA.
Healthy People 2000 Objective	Adapted from 11.14 (Environmental Health).
Measure	Number.
Baseline	1,200 (1998).
Numerator	National Priority List sites.
Denominator	Not applicable.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The list of NPL sites will be “frozen” in the baseline year to monitor improvement for these sites. Additional sites may be added to the database during the decade, but will not be included in monitoring progress for this objective. Progress can be measured by the number of sites on the baseline year list that are “delisted”; delisting indicates a successful cleanup and reduction of health risk.</p> <p>NPL sites are sites that are initially discovered by local and State agencies, businesses, EPA, the U.S. Coast Guard, and the public. If the risk to human health is significant enough, based on the number and toxicity of substances discovered at the site and its ability to affect surrounding populations, then the site is placed on NPL. NPL is a published list of the most hazardous waste sites in the country that are eligible for extensive, long-term cleanup under the Superfund program.</p> <p>See Appendix A for focus area contact information.</p>



8-12b. Resource Conservation and Recovery Act facilities.

National Data Source	Resource Conservation and Recovery Act Information System (RCRIS), OSWER, EPA.
State Data Source	Resource Conservation and Recovery Act Information System (RCRIS), OSWER, EPA.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	2,475 (1998).
Numerator	RCRA facilities.
Denominator	Not applicable.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The list of RCRA sites will be "frozen" in the baseline year to monitor improvement for these sites. Additional sites may be added to the database during the decade, but will not be included in monitoring progress for this objective.</p> <p>RCRA facilities are operations authorized and regulated by the Resource Conservation and Recovery Act. RCRA was enacted by Congress in 1976 to address the issue of how to safely manage and dispose of the huge volumes of municipal and industrial waste generated nationwide. With several amendments, the Act and its subsequent regulations govern the management of nonhazardous (solid) waste, hazardous waste, and underground storage tanks. Specifically, the RCRA program regulates solid waste recycling and disposal; Federal procurement of products containing recycled materials; waste minimization; hazardous waste generators and transporters; hazardous waste treatment, storage, and disposal facilities; and Leaking Underground Storage Facilities.</p> <p>See Appendix A for focus area contact information.</p>



8-12c. Leaking underground storage facilities.

National Data Source	Office of Solid Waste and Emergency Response (OSWER), EPA.
State Data Source	Office of Solid Waste and Emergency Response (OSWER), EPA.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	370,000 (1998).
Numerator	Leaking underground storage facilities.
Denominator	Not applicable.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>This list will be “frozen” in the baseline year to monitor improvement for these sites. Additional sites may be added during the decade, but will not be included in monitoring progress for this objective.</p> <p>The Leaking Underground Storage Tanks Program attempts to identify and eliminate the threat to human health posed by groundwater or soil contamination from petroleum released from these tanks.</p> <p>See Appendix A for focus area contact information.</p>



8-12d. Brownfield properties.

National Data Source	Office of Solid Waste and Emergency Response (OSWER), EPA.
State Data Source	Office of Solid Waste and Emergency Response (OSWER), EPA.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	1500 (1998).
Numerator	All brownfield properties.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>This list will be “frozen” in the baseline year to monitor improvement for these sites. Additional sites may be added to the database during the decade, but will not be included in monitoring progress for this objective.</p>

The term "brownfield" denotes abandoned, idle, or underused industrial or commercial sites where expansion or redevelopment is complicated by real or proposed environmental contamination perceived by the community.

See Appendix A for focus area contact information.



8-13. Reduce pesticide exposures that result in visits to a health care facility.

National Data Source	Toxic Exposure Surveillance System (TESS), American Association of Poison Control Centers.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	27,156 (1997).
Numerator	Number of visits to any facility (other than personal residence) for treatment for pesticide poisoning (see Comments).
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	TESS initially captures pesticide exposures through telephone calls to one of 65 poison control centers from individuals exposed or persons reporting an exposure of another person. These centers serve all of 42 States and parts of 4 other States and the District of Columbia; approximately 258 million people are served by these centers. Individuals report the substance to which the person was exposed, and the product information is coded into a product information database as an insecticide or pesticide. The poison control centers make followup calls to collect information on visits to a health care facility.

See Appendix A for focus area contact information.



8-14. (Developmental) Reduce the amount of toxic pollutants released, disposed of, treated, or used for energy recovery.

Comments

An operational definition could not be specified at the time of publication.

The proposed national and State data source is the Toxic Release Inventory, EPA.

See Appendix A for focus area contact information.



8-15. Increase recycling of municipal solid waste.

National Data Source

Characterization of Municipal Solid Waste, EPA.

State Data Source

Not identified.

Healthy People 2000 Objective

Adapted from 11.8 (Environmental Health).

Measure

Percent.

Baseline

27 (1996).

Numerator

Estimated weight in pounds of municipal solid waste that is recycled or composted.

Denominator

Estimated weight in pounds of all municipal solid waste.

Questions Used To Obtain the National Data

Not applicable.

Expected Periodicity

Annual.

Comments

Estimates of municipal solid waste and the proportion recycled and composted are derived using biennial estimates based on volume of material production and life cycle of materials, as well as samples of waste handled by municipal waste operators. These data are analyzed using an algorithm that produces national estimates. Annual estimates are based on projections from biennial estimates.

This objective differs from Healthy People 2000 objective 11.8, which measured average pounds of solid waste production per person per day and average pounds of solid waste after recycling and composites.

See Appendix A for focus area contact information.



Healthy Homes and Healthy Communities

8-16. Reduce indoor allergen levels.

8-16a. Group 1 dust mite indoor allergens that exceed 2µg per gram of dust in the bed.

National Data Source	National Survey of Lead and Allergens in Housing, NIH, NIEHS, and HUD.
State Data Source	Not specified.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	36.3 (1998–99).
Numerator	Number of homes (in millions) that exceed 2 µg of dust in bed.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.

Comments

Dust samples are collected by vacuuming a specified area (for example, a bed), for a specified amount of time. The sample is collected on a sampling membrane or collection bag that is attached to the vacuum modified for this purpose. The sample is then sent to a laboratory to identify and quantify the presence of specific allergens or other agents.

See Appendix A for focus area contact information

**8-16b. Group 1 dust mite indoor allergens that exceed 10µg per gram of dust in the bed.**

National Data Source	National Survey of Lead and Allergens in Housing, CDC, NIH, NIEHS and HUD.
State Data Source	Not specified.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	18.6 (1998–99).
Numerator	Number of homes (in millions) that exceed 10µg of dust in bed.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-16a for more information.

**8-16c. German cockroach indoor allergens that exceed 0.1µg per gram of dust in the bed.**

National Data Source	National Survey of Lead and Allergens in Housing, CDC, NIH, NIEHS and HUD.
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State Data Source	Not specified.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	4.7 (1998–99).
Numerator	Number of homes (in millions) that exceed 0.1µg of dust in bed.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-16a for more information.



8-17. (Developmental) Increase the number of office buildings that are managed using good indoor air quality practices.

Comments	An operational definition could not be specified at the time of publication. See Appendix A for focus area contact information.
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8-18. Increase the proportion of persons who live in homes tested for radon concentrations.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	11.6 (Environmental Health), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	17 (1998).

Numerator	Number of homeowners/occupants who reported they know what radon is and that they tested their home for radon concentrations.
Denominator	Number of homeowners/occupants who reported that they know what radon is.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey: <ul style="list-style-type: none"> ➤ <i>Have you ever heard of radon, a gas that is found in the air in some homes?</i> ➤ <i>Has your household air been tested for the presence of radon?</i>
Expected Periodicity	Periodic.
Comments	<p>Persons are considered to live in homes tested for radon concentrations if they report that they have heard of radon and that their household air has been tested for the presence of radon.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.</p> <p>See Part C for a discussion of NHIS and Appendix A for focus area contact information.</p>



8-19. Increase the number of new homes constructed to be radon resistant.

National Data Source	National Association of Home Builders Research Center Survey, NAHB.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 11.12 (Environmental Health).
Measure	Number.
Baseline	1,400,000 (1997).
Numerator	Number of new single-family detached housing units built using methods to prevent radon entry or to vent radon to the outside.

Denominator	Not applicable.
Questions Used To Obtain the National Data	Not identified—see Comments.
Expected Periodicity	Annual.
Comments	<p>Radon-resistant home construction methods are characterized by (1) sealing the basement and other parts of the home that are underground to prevent radon from seeping into the house and (2) incorporation of systems that provide a path for radon generated in the soil beneath the foundation to vent to the outside of the home rather than entering the dwelling.</p> <p>The NAHB Research Center (http://www.nahbrc.org) conducts an annual survey of home builders to gather information on a wide variety of home building practices. The survey collects information such as types of houses built, lot sizes, foundation designs, types of doors and windows used by builders, types of lumber used by builders, etc. The survey includes two questions regarding the inclusion of radon-resistant design features in new houses. Radon-resistant features are defined as (1) passive stack subslab/submembrane depressurization, (2) active subslab/submembrane depressurization, and (3) rough-in for subslab depressurization.</p> <p>The survey sample is divided into the nine U.S. Census divisions. The survey results are weighted to the Census Bureau's data for housing starts in each Census Division. Survey results are presented by Census Division, State-market areas, and the three EPA radon zones. There are thirty-two State-market areas composed of groups of smaller States, larger States (for example, California and Texas) divided into two areas, and the remaining States.</p> <p>Because survey results can be skewed by large production builders, responses from these builders are limited.</p> <p>This objective differs from Healthy People 2000 objective 11.12, which called for States to adopt radon-resistant building standards.</p> <p>See Appendix A for focus area contact information.</p>

- 8-20. (Developmental) Increase the proportion of the Nation's primary and secondary schools that have official school policies ensuring the safety of students and staff from environmental hazards, such as chemicals in special classrooms, poor indoor air quality, asbestos, and exposure to pesticides.**

Comments

An operational definition could not be specified at the time of publication.

The expected national data source is the School Health Policies and Programs Study (SHPPS), CDC, DASH; no State data source has been identified. The measure will be a percent and the expected numerator will be the number of schools that have inspected and provided appropriate maintenance for environmental hazards (such as asbestos, pesticides or chemicals in laboratories or workshops) during the 12 months preceding the survey. The expected denominator will be the number of schools. The expected question used to obtain these data, from the 2000 School Health Policies and Programs Study, School Policy and Environment School questionnaire, is:

- *During the past 12 months, have environmental hazards such as, asbestos, pesticides or chemicals in labs or workshops been inspected and provided appropriate maintenance?*

See Appendix A for focus area contact information.



- 8-21. (Developmental) Ensure that State health departments establish training, plans, and protocols, and conduct annual multi-institutional exercises to prepare for response to natural and technological disasters.**

Comments

An operational definition could not be specified at the time of publication.

The proposed data sources are surveys by the Association of State and Territorial Health Officials and PHF.

See Appendix A for focus area contact information.

8-22. Increase the proportions of persons living in pre-1950s housing that has been tested for the presence of lead-based paint.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	11.11 (Environmental Health), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	16 (1998).
Numerator	Number of persons who report living in houses built before 1950 that have been tested for the presence of lead-based paint.
Denominator	Number of persons who report living in houses built before 1950.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>[NUMERATOR:]</p> <p>➤ <i>Has paint from this home ever been analyzed for lead content?</i></p> <p>[DENOMINATOR:]</p> <p>➤ <i>Was your home built before 1950?</i></p>
Expected Periodicity	Periodic.
Comments	<p>The numerator for this objective is composed of respondents who report that paint from their home has been analyzed for lead content and their home was built before 1950.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NHIS and Appendix A for focus area contact information.</p>

8-23. Reduce the proportion of occupied housing units that are substandard.

National Data Source	American Housing Survey (AHS), DOC, Bureau of the Census.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	6.2 (1995).
Numerator	Number of housing units identified with moderate or severe physical problems—see Comments.
Denominator	Number of housing units that are regularly occupied.
Questions Used To Obtain the National Data	From the 1995 American Housing Survey:

[NUMERATOR:]

- *Does the (house/apartment) have a bathtub or shower for this household's use only?*
- *Does the (house/apartment) have a flush toilet for this household's use only?*
- *In the last 3 months, was there any time when all the toilets in the home were not working?*
 - *How many of these breakdowns lasted 6 hours or more?*
- *Is all the wiring in the finished areas of your home concealed either in walls or metal coverings?*
- *Does every room have an electric outlet or wall plug that works?*
- *Have any fuses blown or circuit breakers tripped in the last 3 months?*
 - *How many times in the last 3 months?*
- *Has water leaked into your home from outdoors in the last 12 months?*
 - *Where did the water come in?*
- *Have there been water leaks in the (house/apartment) from INSIDE the building in the last 12 months?*
 - *Where did the water come in?*

- *Does the (house/apartment) have hot and cold piped water?*
 - *What fuel is used MOST to heat the water?*
- *Was your home ever completely without running water in the last 3 months?*
 - *How many times was it not available for 6 hours or more?*
- *Does your home have a refrigerator?*
 - *Is it more than 5 years old?*
- *Does your (house/apartment) have a cookstove or range with an oven?*
- *Does your (house/apartment) have an oven? cooking burners?*
 - [If yes:]
 - *(Is it/are they) more than 5 years old?*
 - *What fuel is used MOST for cooking?*
- *What type of heating equipment is used MOST to heat the (house/apartment)?*
- *Last winter was there any time when the (house/apartment) was so cold for 24 hours or more that it caused anyone in your household discomfort?*
 - *Was that because the heating equipment broke down?*
 - [If yes:]
 - *How many times did (it/they/all) break down for 6 hours or more?*
 - *Was it cold for any other reason?*
 - [If yes:]
 - *What was the reason?*
- *Does the (house/apartment) have a porch, deck, balcony, or patio?*
- *Does the (house/apartment) have open cracks or holds in the inside walls or ceilings?*
- *Does the (house/apartment) have holes in the floors?*
- *Does the (house/apartment) have any area of peeling paint or broken plaster bigger than 8 inches by 11 inches?*
- *In the last 3 months, have you seen any rats or signs of rats in the building?*

[DENOMINATOR:]

➤ Does (household member) usually live here?

Expected Periodicity

Biennial.

Comments

A housing unit has severe physical problems if it has any of the following five problems:

Plumbing. Lacking hot or cold piped water or a flush toilet, or lacking both bathtub and shower, all inside the structure (and for the exclusive use of the unit, unless there are two or more full bathrooms).

Heating. Having been uncomfortably cold last winter for 24 hours or more because the heating equipment broke down, and it broke down at least three times last winter for at least 6 hours each time.

Electric. Having no electricity, or all of the following three electric problems: exposed wiring, a room with no working wall outlet, and three blown fuses or tripped circuit breakers in the last 90 days.

Hallways. Having all of the following four problems in public areas: no working light fixtures, loose or missing steps, loose or missing railings, and no working elevator.

Upkeep. Having any five of the following six maintenance problems: (1) water leaks from the outside, such as from the roof, basement, windows, or doors; (2) leaks from inside structure such as pipes or plumbing fixtures; (3) holes in the floors; (4) holes or open cracks in the walls or ceilings; (5) more than 8 inches by 11 inches of peeling paint or broken plaster; or (6) signs of rats in the last 90 days.

A unit has moderate physical problems if it has any of the following five problems, but none of the severe problems:

Plumbing. On at least three occasions during the last 3 months, all the flush toilets were broken down at the same time for 6 hours or more (see "Flush toilet and flush toilet breakdowns").

Heating. Having unvented gas, oil, or kerosene heaters as the primary heating equipment.

Kitchen. Lacking a kitchen sink, refrigerator, oven or burners inside the structure for the exclusive use of the unit.

Hallways. Having any three of the four problems listed under severe physical problems.

Upkeep. Having any three or four of the six problems listed under severe physical problems.

See Appendix A for focal area contact information.



Infrastructure and Surveillance

8-24. Reduce exposure to pesticides as measured by urine concentrations of metabolites.

8-24a. 1-naphthol (carbaryl).

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Concentration (µg/g).
Baseline	36.0 (1988–94).
Numerator	Concentration level of 1-naphthol (carbaryl) in urine samples at which 95 percent of the population is below the level.
Denominator	Not applicable.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	Data are reported in concentrations of micrograms per gram of urine and are corrected for kidney function.

See Part C for a discussion of NHANES and
Appendix A for focus area contact information.



8-24b. Paranitrophenol (methyl parathion and parathions).

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Concentration ($\mu\text{g/g}$).
Baseline	3.8 (1988–94).
Numerator	Concentration level of paranitrophenol (methyl parathion and parathion) in urine samples at which 95 percent of the population is below the level.
Denominator	Not applicable.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	See Comments provided with objective 8-24a for more information.



8-24c. 3, 5, 6-trichloro-2-pyridinol (chlorpyrifos).

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Concentration ($\mu\text{g/g}$).
Baseline	8.3 (1988–94).

Numerator	Concentration level of 3, 5, 6-trichloro-2 pyridinol (chlorpyrifos) in urine samples at which 95 percent of the population is below the level.
Denominator	Not applicable.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	See Comments provided with objective 8-24a for more information.



8-24d. Isopropoxyphenol (propoxur).

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Concentration (µg/g).
Baseline	1.6 (1988–94)
Numerator	Concentration level of isopropoxyphenol (propoxur) in urine samples at which 95 percent of the population is below the level.
Denominator	Not applicable.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	See Comments provided with objective 8-24a for more information.



8-25. (Developmental) Reduce exposure of the population to pesticides, heavy metals, and other toxic chemicals, as measured by blood and urine concentrations of the substances or their metabolites.

Heavy metals

8-25a. Arsenic.

Comments

An operational definition could not be specified at the time of publication. The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25b. Cadmium.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25c. Lead.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25d. Manganese.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25e. Mercury.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



Pesticides

8-25f. 2, 4-D.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25g. o-phenylphenol.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25h. Permethrins.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25i. Diazinon.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



Persistent chemicals

8-25j. Polychlorinated biphenyls.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.

8-25k. Dioxins.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25l. Furans.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



Organochlorine compounds

8-25m. Chlordane.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25n. Dieldrin.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25o. DDT.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-25p. Lindane.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



8-26. (Developmental) Improve quality, utility, awareness, and use of existing information systems for environmental health.

Comments

An operational definition could not be specified at the time of publication.

The proposed data sources are the Toxics Release Inventory, EPA, and the Environmental Defense Fund.

The proposed measure would be a tabulation of the number of times that five representative information systems (for example, TOXLINE, IRIS, RTECS, HazDat, AIRS) are accessed annually via the Internet.

See Appendix A for focus area contact information.



8-27. Increase or maintain the number of Territories, Tribes, and States and the District of Columbia that monitor diseases or conditions that can be caused by exposure to environmental hazards.

8-27a. Lead poisoning.

National Data Source	Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.
State Data Source	Not identified.
Healthy People 2000 Objective	11.16 (Environmental Health).
Measure	Number.
Baseline	51 (1997).
Numerator	Number of States and the District of Columbia monitoring lead poisoning.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:</p> <p>➤ <i>For which environmental disease are you coordinating a surveillance system? (Please check one)</i></p> <p>[List of diseases includes:]</p> <p>_____ <i>Lead Poisoning (Please circle: adult child)</i></p>
Expected Periodicity	Periodic.
Comments	A State is considered as monitoring lead poisoning if they report coordinating a surveillance system for either children or adults.

An operational definition for number of Tribes and number of Territories was not available at the time of publication, and no proposed data source for Tribes and Territories has been identified, therefore, data for Tribes and Territories are developmental.

See Appendix A for focus area contact information.



8-27b. Pesticide poisoning.

National Data Source	Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.
State Data Source	Not identified.
Healthy People 2000 Objective	11.16 (Environmental Health).
Measure	Number.
Baseline	20 (1997).
Numerator	Number of States monitoring pesticide poisoning.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:</p> <p>➤ <i>For which environmental disease are you coordinating a surveillance system? (Please check one)</i></p> <p>[List of diseases includes:]</p> <p>_____ <i>Pesticide Poisoning</i></p>
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-27a for more information.



8-27c. Mercury poisoning.

National Data Source	Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.
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State Data Source	Not identified.
Healthy People 2000 Objective	11.16 (Environmental Health).
Measure	Number.
Baseline	14 (1997).
Numerator	Number of States monitoring mercury poisoning.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:</p> <p>➤ <i>For which environmental disease are you coordinating a surveillance system? (Please check one)</i></p> <p>[List of diseases includes:]</p> <p>_____ <i>Mercury Poisoning</i></p>
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-27a for more information.



8-27d. Arsenic poisoning.

National Data Source	Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.
State Data Source	Not identified.
Healthy People 2000 Objective	11.16 (Environmental Health).
Measure	Number.
Baseline	10 (1997).
Numerator	Number of States monitoring arsenic poisoning.
Denominator	Not applicable.
Questions Used To Obtain the National Data	From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:

- *For which environmental disease are you coordinating a surveillance system? (Please check one)*

[List of diseases includes:]

_____ *Arsenic Poisoning*

Expected Periodicity

Periodic.

Comments

See Comments provided with objective 8-27a for more information.



8-27e. Cadmium poisoning.

National Data Source

Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.

State Data Source

Not identified.

Healthy People 2000 Objective

11.16 (Environmental Health).

Measure

Number.

Baseline

10 (1997).

Numerator

Number of States monitoring cadmium poisoning.

Denominator

Not applicable.

Questions Used To Obtain the National Data

From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:

- *For which environmental disease are you coordinating a surveillance system? (Please check one)*

[List of diseases includes:]

_____ *Cadmium Poisoning*

Expected Periodicity

Periodic.

Comments

See Comments provided with objective 8-27a for more information.



8-27f. Methemoglobinemia.

National Data Source	Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.
State Data Source	Not identified.
Healthy People 2000 Objective	11.16 (Environmental Health).
Measure	Number.
Baseline	9 (1997).
Numerator	Number of States monitoring methemoglobinemia.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:</p> <p>➤ <i>For which environmental disease are you coordinating a surveillance system? (Please check one)</i></p> <p>[List of diseases includes:]</p> <p>_____ <i>Methemoglobinemia</i></p>
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-27a for more information.



8-27g. Acute chemical poisoning.

National Data Source	Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.
State Data Source	Not identified.
Healthy People 2000 Objective	11.16 (Environmental Health).
Measure	Number.
Baseline	8 (1997).
Numerator	Number of States monitoring acute chemical poisoning.
Denominator	Not applicable.

Questions Used To Obtain the National Data	<p>From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:</p> <p>➤ <i>For which environmental disease are you coordinating a surveillance system? (Please check one)</i></p> <p>[List of diseases includes:]</p> <p>_____ <i>Acute chemical Poisoning</i></p>
Expected Periodicity	Periodic.
Comments	<p>Acute chemical poisoning refers to unintentional poisonings caused by nonmedicinal chemicals not identified elsewhere in the objective.</p> <p>See Comments provided with objective 8-27a for more information.</p>



8-27h. Carbon monoxide poisoning.

National Data Source	Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.
State Data Source	Not identified.
Healthy People 2000 Objective	11.16 (Environmental Health).
Measure	Number.
Baseline	7 (1997).
Numerator	Number of States monitoring carbon monoxide poisoning.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:</p> <p>➤ <i>For which environmental disease are you coordinating a surveillance system? (Please check one)</i></p> <p>[List of diseases includes:]</p> <p>_____ <i>Carbon monoxide Poisoning</i></p>
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-27a for more information.

8-27i. Asthma.

National Data Source	Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.
State Data Source	Not identified.
Healthy People 2000 Objective	11.16 (Environmental Health).
Measure	Number.
Baseline	6 (1997).
Numerator	Number of States monitoring asthma.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:</p> <p>➤ <i>For which environmental disease are you coordinating a surveillance system? (Please check one)</i></p> <p><i>[List of diseases includes:]</i></p> <p>_____ <i>Asthma</i></p>
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-27a for more information.



8-27j. Hyperthermia.

National Data Source	Periodic surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.
State Data Source	Not identified.
Healthy People 2000 Objective	11.16 (Environmental Health).
Measure	Number.
Baseline	4 (1997).
Numerator	Number of States monitoring hyperthermia.
Denominator	Not applicable.

Questions Used To Obtain the National Data

From the 1997 Survey of State and Territorial Environmental Public Health Surveillance Systems:

- *For which environmental disease are you coordinating a surveillance system? (Please check one)*

[List of diseases includes:]

_____ *Hyperthermia*

Expected Periodicity

Periodic.

Comments

See Comments provided with objective 8-27a for more information.



8-27k. (Developmental) Hypothermia.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is Periodic Surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.

See Appendix A for focus area contact information.



8-27l. (Developmental) Skin cancer.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is Periodic Surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.

See Appendix A for focus area contact information.



8-27m. (Developmental) Malignant melanoma.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is Periodic Surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.

See Appendix A for focus area contact information.



8-27n. (Developmental) Other skin cancer.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is Periodic Surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.

See Appendix A for focus area contact information.



8-27o. (Developmental) Birth defects.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is Periodic Surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.

See Appendix A for focus area contact information.



8-28. (Developmental) Increase the number of local health departments or agencies that use data from surveillance of environmental risk factors as part of their vector control programs.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is Periodic Surveys by the Public Health Foundation and the Council of State and Territorial Epidemiologists.

See Appendix A for focus area contact information.

Global Environmental Health

8-29. Reduce the global burden of disease due to poor water quality, sanitation, and personal and domestic hygiene.

Comments

A complete operational definition could not be specified at the time of publication.

The 1990 baseline data (2,688,200) for this objective represent the worldwide estimate of deaths attributable to poor water quality, sanitation, and personal hygiene; U.S. estimates are currently unavailable.^{1, 2}

See Appendix A for focus area contact information.



8-30. Increase the proportion of the population in the United States-Mexico border region who have adequate drinking water and sanitation facilities.

Wastewater sewer service

8-30a. Ciudad Acuna.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	39 (1997) (Ciudad Acuna).
Numerator	Number of residents of Ciudad Acuna who have wastewater sewer service.
Denominator	Number of Ciudad Acuna resident persons.
Population Targeted	Resident population of Ciudad Acuna.
Questions Used To Obtain the National Data	Not applicable.

Expected Periodicity	Periodic.
Comments	<p>The 200-kilometer border region is home to more than 10.5 million people, with about 6.2 million in the United States and 4.3 million in Mexico. In 1996, there were approximately 250,000 people in the Mexico border cities without potable water and 1.5 million people without sewer connections. In Mexico, the population figures are official estimates for 1998 based on 1990 census data.</p> <p>In the United States, there is virtually 100 percent coverage in the major cities; however, the data do not exist for the smaller border towns. These data will be forthcoming in later Border XXI Indicators Reports. The data for Mexico are from the selected major cities, and, much like the United States, the data for the smaller border towns are not known at this time.</p> <p>See Appendix A for focus area contact information.</p>



8-30b. Matamoros.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	47 (1997) (Matamoros).
Numerator	Number of residents of Matamoros who have wastewater sewer service.
Denominator	Number of Matamoros resident persons.
Population Targeted	Resident population of Matamoros.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.

Comments	See Comments provided with objective 8-30a for more information.
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8-30c. Mexicali.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	80 (1997) (Mexicali).
Numerator	Number of residents of Mexicali who have wastewater sewer service.
Denominator	Number of Mexicali resident persons.
Population Targeted	Resident population of Mexicali.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.



8-30d. Nogales, Sonora.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.

Baseline	81 (1997) (Nogales, Sonora).
Numerator	Number of residents of Nogales, Sonora, who have wastewater sewer service.
Denominator	Number of Nogales, Sonora, resident persons.
Population Targeted	Resident population of Nogales, Sonora.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.



8-30e. Piedras Negras.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	80 (1997) (Piedras Negras).
Numerator	Number of residents of Piedras Negras who have wastewater sewer service.
Denominator	Number of Piedras Negras resident persons.
Population Targeted	Resident population of Piedras Negras.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.

8-30f. Reynosa.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	57 (1997) (Reynosa).
Numerator	Number of residents of Reynosa who have wastewater sewer service.
Denominator	Number of Reynosa resident persons.
Population Targeted	Resident population of Reynosa.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.

**Wastewater receiving treatment****8-30g. Ciudad Acuna.**

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	0 (1997) (Ciudad Acuna).
Numerator	Number of residents of Ciudad Acuna who have wastewater treatment service.

Denominator	Number of Ciudad Acuna resident persons.
Population Targeted	Resident population of Ciudad Acuna.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.



8-30h. Matamoros.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	0 (1997) (Matamoros).
Numerator	Number of residents of Matamoros who have wastewater treatment service.
Denominator	Number of Matamoros resident persons.
Population Targeted	Resident population of Matamoros.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.



8-30i. Mexicali.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	72 (1997) (Mexicali).
Numerator	Number of residents of Mexicali who have wastewater treatment service.
Denominator	Number of Mexicali resident persons.
Population Targeted	Resident population of Mexicali.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.

**8-30j. Nogales, Sonora.**

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	100 (1997) (Nogales, Sonora).
Numerator	Number of residents of Nogales, Sonora, who have wastewater treatment service.

Denominator	Number of Nogales, Sonora, resident persons.
Population Targeted	Resident population of Nogales, Sonora.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.



8-30k. Piedras Negras.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	0 (1997) (Piedras Negras).
Numerator	Number of residents of Piedras Negras who have wastewater treatment service.
Denominator	Number of Piedras Negras resident persons.
Population Targeted	Resident population of Piedras Negras.
Questions Used To Obtain the National Data	Not identified.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.



8-30I. Reynosa.

National Data Sources	EPA; Mexico's Comisión Nacional de Agua; State/local health departments; American Water Works Association; Rural Water Association; U.S.-Mexican Border Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	100 (1997) (Reynosa).
Numerator	Number of residents of Reynosa who have wastewater treatment service.
Denominator	Number of Reynosa resident persons.
Population Targeted	Resident population of Reynosa.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 8-30a for more information.

References

1. Huttly, S. Water, sanitation and personal hygiene. In: Murray, C.J., and Lopez, A.D., eds. *Quantifying Global Health Risks: The Burden of Disease Attributable to Selected Risk Factors*. Cambridge, MA: Harvard University Press, 1996.
2. The World Resources Institute. *World Resources: A Guide to the Global Environment*. Oxford: Oxford University Press, 1996–1997.

9

Family Planning

- 9-1 Intended pregnancy
- 9-2 Birth spacing
- 9-3 Contraceptive use
- 9-4 Contraceptive failure
- 9-5 Emergency contraception
- 9-6 Male involvement in pregnancy prevention
- 9-7 Adolescent pregnancy
- 9-8 Abstinence before age 15 years
 - 9-8a Females
 - 9-8b Males
- 9-9 Abstinence among adolescents aged 15 to 17 years
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- 9-10 Pregnancy prevention and sexually transmitted disease (STD) protection
 - Condom at first intercourse:
 - 9-10a Females
 - 9-10b Males
 - Condom plus hormonal method at first intercourse:
 - 9-10c Females
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 - Condom at last intercourse:
 - 9-10e Females
 - 9-10f Males
 - Condom plus hormonal method at last intercourse:
 - 9-10g Females
 - 9-10h Males
- 9-11 Pregnancy prevention education
- 9-12 Problems in becoming pregnant and maintaining a pregnancy
- 9-13 Insurance coverage for contraceptive supplies and services

9-1. Increase the proportion of pregnancies that are intended.

National Data Sources	National Survey of Family Growth (NSFG), CDC, NCHS; National Vital Statistics System (NVSS), CDC, NCHS; Abortion Provider Survey, The Alan Guttmacher Institute (AGI); Abortion Surveillance Data, CDC, NCCDPHP.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.2 (Family Planning).
Measure	Percent.
Baseline	51 (1995).
Numerator	Number of intended births among females aged 15 to 44 years.
Denominator	Number of live births plus abortions among females aged 15 to 44 years.
Population Targeted	U.S. resident population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Family Growth:</p> <ul style="list-style-type: none">➤ <i>Before you became pregnant this time, was the reason you did not use any birth control methods because you, yourself wanted to become pregnant?</i>➤ <i>At the time you became pregnant, did you, yourself actually want to have a baby at some time?</i>➤ <i>So would you say you became pregnant too soon, at about the right time, or later than you wanted?</i><ul style="list-style-type: none">1) <i>Too soon</i>2) <i>Right time</i>3) <i>Later</i>4) <i>Didn't care</i>
Expected Periodicity	Periodic.
Comments	Intended pregnancies include births that were wanted at the time of conception. Births that were wanted at the time of conception are those resulting from pregnancies that happened at the right time, later than wanted or those answering didn't care. All abortions are considered unintended pregnancies.

Estimates of pregnancies that were intended are derived from the following sources: (1) live births to U.S. residents in 1994; (2) the proportion of recent births that were intended according to the 1995 NSFG; and (3) estimates of induced abortions based on reports by CDC and The Alan Guttmacher Institute (AGI). AGI's national estimates of abortions, based on surveys it conducts of all known abortion providers, are distributed by age, race, marital status, and ethnicity according to estimates prepared by CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), which are based on reports from State health departments.

The proportion of births intended (females who wanted to become pregnant and wanted to have a baby at sometime and became pregnant at the right time, later, or didn't care) from NSFG are applied to all resident live births, divided by all births and abortions combined.

Information about potential sources of error in the data sources have been published.^{1, 2, 3}

Known pregnancies that ended in fetal loss (for example, miscarriage, stillbirth, or ectopic pregnancy) are excluded. However, it was found that incorporating information on the planning status of pregnancies resulting in fetal loss, as reported in the 1995 NSFG, had very little impact on the proportions shown.

This objective is adapted from a measure in Healthy People 2000 objective 5.2, which tracked the proportion of pregnancies that were unintended. This measure tracks the proportion of pregnancies that are intended.

See Part C for a description of NSFG and NVSS and Appendix A for focus area contact information.



9-2. Reduce the proportion of births occurring within 24 months of a previous birth.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	11 (1995).
Numerator	Number of females aged 15 to 44 years whose most recent live birth occurred within 24 months of a previous live birth.
Denominator	Number of females aged 15 to 44 years with at least one live birth.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Family Growth:</p> <ul style="list-style-type: none">➤ <i>How many times have you been pregnant altogether?</i> <p>[For each pregnancy:]</p> <ul style="list-style-type: none">➤ <i>In which of the ways did the pregnancy end?</i><ul style="list-style-type: none">(a) <i>Miscarriage</i>(b) <i>Still birth</i>(c) <i>Abortion</i>(d) <i>Ectopic or tubal pregnancy</i>(e) <i>Live birth by Cesarean section</i>(f) <i>Live birth by vaginal delivery</i> <p>[For each live birth:]</p> <ul style="list-style-type: none">➤ <i>On what date was (<u>baby's name</u>) born?</i>
Expected Periodicity	Periodic.
Comments	<p>A female is considered to have had a birth within 24 months of a previous birth if she had consecutive pregnancies ending in a live birth by Cesarean section or live birth by vaginal delivery.</p> <p>The interval between consecutive live births is derived from the date of birth.</p> <p>Vaginal delivery includes delivery through natural or induced labor.</p>

Questions addressing how the pregnancy ended and date baby was born are repeated based on the number of pregnancies.

See Part C for a description of NSFG and Appendix A for focus area contact information.



9-3. Increase the proportion of females at risk of unintended pregnancy (and their partners) who use contraception.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	5.12 (Family Planning).
Measure	Percent.
Baseline	93 (1995).
Numerator	Number of at-risk females aged 15 to 44 years who currently use a method of contraception other than withdrawal.
Denominator	Number of at-risk females aged 15 to 44 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1995 National Survey of Family Growth:

[NUMERATOR:]

- *Please write the methods you used each month on the calendar. I need to know about all the methods you used, so if you used more than one method, please write down all methods you used that month.*

- 1) *Birth control pills*
- 2) *Condom*
- 3) *Partner's vasectomy*
- 4) *Diaphragm*
- 5) *Foam*
- 6) *Jelly or cream*
- 7) *Cervical cap*
- 8) *Suppository, insert*
- 9) *Today sponge*
- 10) *Female condom, vaginal pouch*
- 11) *IUD, Coil, Loop*
- 12) *Norplant*
- 13) *Depo-provera, Injectables*
- 14) *Morning after pill*
- 15) *Rhythm or safe period by calendar*
- 16) *Safe period by temperature, or cervical mucus test, or natural family planning*
- 17) *Withdrawal, pulling out*
- 18) *Respondent sterile*
- 19) *Partner sterile*
- 20) *Other method (specify)*

[DENOMINATOR:]

- *Is the reason you are not using a method of birth control now because you, yourself, want to become pregnant as soon as possible?*
- *Many women have times when they are not having intercourse at all, for example, because of pregnancy, separation, not dating anyone, illness, or other reasons. Since (Date), have there been any times when you were not having intercourse at all for one month or more?*
- *What months and years were those?*

Expected Periodicity

Periodic.

Comments

A female (and her partner) is considered to be at risk of unintended pregnancy if there is a negative response to the denominator questions above on wanting to become pregnant (first question) or not having intercourse (second question).

"At risk" females are those who had intercourse in the 3 months prior to the survey who were not pregnant, nor seeking pregnancy, nor post partum, nor (themselves or partners) surgically or nonsurgically sterile.

"Currently using" refers to having used any contraceptive method (categories 1, 2, 4 through 16 above) other than sterilization or withdrawal in the month of the interview.

An unintended pregnancy is one that was not wanted at the time of conception or not wanted at all.

See Part C for a description of NSFG and Appendix A for focus area contact information.



9-4. Reduce the proportion of females experiencing pregnancy despite use of a reversible contraceptive method.

National Data Sources	National Survey of Family Growth (NSFG), CDC, NCHS; Abortion Patient Survey, The Alan Guttmacher Institute (AGI).
State Data Source	Not identified.
Healthy People 2000 Objective	5.7 (Family Planning).
Measure	Percent.
Baseline	13 (1995).
Numerator	Number of pregnancies that occur within the first 12 months of reported continuous use of a reversible contraceptive method among females aged 15 to 44 years, and their partners.
Denominator	Number of consecutive months that a reversible contraceptive method was used by females aged 15 to 44 years, and their partners.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1995 National Survey of Family Growth:

- *For about how many months in a row had you been using that method?*

Less than 1 month

1 month

2 months

3 months

4 months

5 months

6 months

7 months

8 months

9 months

10 months

11 months

12 months

13 months

14 months

15 months

16 months

17 months

18-24 months

25-26 months

27-28 months

29-36 months

37 or more months (3 or more years)

- *Had you ever used that method before the months specified above?*

- *Had you stopped using all methods to prevent pregnancy before you became pregnant this time?*

Expected Periodicity

Periodic.

Comments

Pregnancies include live births, miscarriages, or induced abortions.

Females are considered to have experienced pregnancy despite use of a reversible method if there was continuous method use (in 12-month intervals) and they became pregnant during a month of use of one or more of the following methods: birth control pills, condom (rubber), diaphragm, foam/jelly/cream, cervical cap, suppository, insert, Today™ sponge, female condom (vaginal pouch), IUD, coil, loop, Norplant, Depo-provera, injectables, withdrawal (pulling out), rhythm/natural family planning, or emergency contraception/morning-after pill.

NSFG data are adjusted for underreporting of abortions according to AGI's Abortion Patient Survey. Detailed information on adjustment procedure, contraceptive methods and failure rates have been published by AGI.⁴

See Part C for a description of NSFG and Appendix A for focus area contact information.

9-5. (Developmental) Increase the proportion of health care providers who provide emergency contraception.

Comments An operational definition could not be specified at the time of publication.

A proposed national data source is The Alan Guttmacher Institute (AGI).

See Appendix A for focus area contact information.



9-6. (Developmental) Increase male involvement in pregnancy prevention and family planning efforts.

Comments An operational definition could not be specified at the time of publication.

A proposed national data source is the National Survey of Family Growth (NSFG), CDC, NCHS.

Proposed questions to be used to obtain the data are scheduled to be included in the 2001 NSFG.

NSFG collect comparable data on males aged 15 to 49 years starting with data collected in 2001.

See Appendix A for focus area contact information.



9-7. Reduce pregnancies among adolescent females.

National Data Sources	Abortion Provider Survey, The Alan Guttmacher Institute (AGI); Abortion Surveillance Data, CDC, NCCDPHP; National Vital Statistics System (NVSS), CDC, NCHS; National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	5.1 (Family Planning).
Measure	Rate.
Baseline	68 (1996).

Numerator	Number of pregnancies among females aged 15 to 17 years.
Denominator	Number of adolescent females aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population; U.S. resident population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Family Growth:</p> <p>➤ <i>(For fetal losses) In which of the ways did your pregnancy end?</i></p> <ol style="list-style-type: none"> 1) <i>Miscarriage</i> 2) <i>Stillbirth</i> 3) <i>Abortion</i> 4) <i>Ectopic or tubal pregnancy</i> 5) <i>Live birth by Cesarean section</i> 6) <i>Live birth by vaginal delivery</i> <p><i>[Responses 1 and 2 are used as indicators of fetal loss.]</i></p>
Expected Periodicity	Periodic.
Comments	<p>Adolescent pregnancies are the sum of all U.S. resident live births, induced abortions, and fetal losses to females aged 15 to 17 years.</p> <p>Data on live births are counts of all births to U.S. residents occurring in the United States. Estimates of induced abortion are based on reports by CDC and The Alan Guttmacher Institute (AGI). AGI's national estimates of abortions, based on surveys it conducts of all known abortion providers, are distributed by age and race according to estimates prepared by CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), based on reports of induced abortions from selected State health departments.</p> <p>Estimates of fetal losses are estimates from the 1995 NSFG. Females participating in this survey were asked to report the dates and outcomes of each of their pregnancies in the past 5 years, including spontaneous fetal losses (miscarriages, stillbirths) from recognized pregnancies.</p> <p>Fetal losses refer to pregnancies that end in miscarriage or stillbirth.</p> <p>See Part C for a description of NSFG and NVSS and Appendix A for focus area contact information.</p>

9-8. Increase the proportion of adolescents who have never engaged in sexual intercourse before age 15 years.

9-8a. Females.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.4 (Family Planning) (also 18.3 and 19.9).
Measure	Percent.
Baseline	81 (1995).
Numerator	Number of females aged 15 to 19 years who had no sexual intercourse with a male before age 15.
Denominator	Number of females aged 15 to 19 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Family Growth:</p> <p>➤ <i>At any time in your life, have you ever had sexual intercourse with a man, that is, made love, had sex, or gone all the way?</i></p> <p>[If yes:]</p> <p>○ <i>Please look at the calendar and think back to the very first time in your life that you ever had sexual intercourse with a man. In what month and year was that?</i></p> <p>_____Month _____Year</p>
Expected Periodicity	Periodic.
Comments	<p>Females are considered to have never had sexual intercourse before age 15 if they report that they either never had sexual intercourse with a male or their age at first intercourse was greater than 15 years.</p> <p>This objective is adapted from Healthy People 2000 objective 5.4, which tracked the proportion of adolescents aged 15 to 17 years who engaged in sexual intercourse. This measure tracks the proportion of females aged 15 to 19 years who have never engaged in sexual intercourse.</p>

See Part C for a description of NSFG and Appendix A for focus area contact information.



9-8b. Males.

National Data Source	National Survey of Adolescent Males (NSAM), Urban Institute.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.4 (Family Planning) (also 18.3 and 19.9).
Measure	Percent.
Baseline	79 (1995).
Numerator	Number of males aged 15 to 19 years who had no sexual intercourse with a female before age 15.
Denominator	Number of males aged 15 to 19 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Adolescent Males:</p> <p>➤ <i>Have you ever had sexual intercourse with a female (sometimes this is called “making love,” “having sex” or “going all the way”)?</i></p> <p>[Followed by a question of when the intercourse occurred, similar to that used in objective 9.8a]</p>
Expected Periodicity	Periodic.
Comments	<p>Males are considered to have never had sexual intercourse before age 15 if they report that they either never had sexual intercourse with a female or their age at first intercourse was greater than 15 years.</p> <p>This objective is adapted from Healthy People 2000 objective 5.4, which tracked the proportion of adolescents aged 15 to 17 years who engaged in sexual intercourse. This measure tracks the proportion of males aged 15 to 19 years who have never engaged in sexual intercourse.</p>

NSFG will collect comparable data on males aged 15 to 49 years starting with data collected in 2001 and will thereby replace NSAM for tracking of this measure.

See Appendix A for focus area contact information.



9-9. Increase the proportion of adolescents who have never engaged in sexual intercourse.

9-9a. Females.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.4 (Family Planning) (also 18.3 and 19.9).
Measure	Percent.
Baseline	62 (1995).
Numerator	Number of females aged 15 to 17 years who had never had sexual intercourse with a male.
Denominator	Number of females aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1995 National Survey of Family Growth: ➤ <i>At any time in your life, have you ever had sexual intercourse with a man, that is, made love, had sex, or gone all the way?</i>
Expected Periodicity	Periodic.
Comments	<p>This objective is adapted from Healthy People 2000 objective 5.4, which tracked the proportion of adolescents aged 15 to 17 years who engaged in sexual intercourse. This measure tracks the proportion of females aged 15 to 17 years who have never engaged in sexual intercourse.</p> <p>See Part C for a description of NSFG and Appendix A for focus area contact information.</p>

9-9b. Males.

National Data Source	National Survey of Adolescent Males (NSAM), Urban Institute.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.4 (Family Planning) (also 18.3 and 19.9).
Measure	Percent.
Baseline	57 (1995).
Numerator	Number of males aged 15 to 17 years who had never had sexual intercourse with a female.
Denominator	Number of males aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1995 National Survey of Adolescent Males: ➤ <i>Have you ever had sexual intercourse with a female (sometimes this is called "making love," "having sex" or "going all the way")?</i>
Expected Periodicity	Periodic.
Comments	<p>This objective is adapted from Healthy People 2000 objective 5.4, which tracked the proportion of adolescents aged 15 to 17 years who engaged in sexual intercourse. This measure tracks the proportion of males aged 15 to 17 years who have never engaged in sexual intercourse.</p> <p>NSFG will collect comparable data on males aged 15 to 49 years starting with data collected in 2001 and will thereby replace NSAM for tracking of this measure.</p> <p>See Appendix A for focus area contact information.</p>



9-10. Increase the proportion of sexually active, unmarried adolescents aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protection against disease.

9-10a. Condom at first intercourse: Females.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.6 (Family Planning).
Measure	Percent.
Baseline	67 (1995).
Numerator	Number of sexually experienced, unmarried females aged 15 to 17 years who used a condom at first intercourse.
Denominator	Number of sexually experienced, unmarried females aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Family Growth:</p> <p>➤ <i>What is your current marital status? Are you...</i></p> <ol style="list-style-type: none">1) <i>Married</i>2) <i>Widowed</i>3) <i>Divorced</i>4) <i>Separated, because you and your husband are not getting along</i>5) <i>Have you never been married?</i> <p>[Following a series of questions on when sexual intercourse with a man occurred and whether or not the sexual intercourse was voluntary:]</p>

- *The very first time you ever used a birth control method, which method did you use? If you used more than one method that first time, please tell me about it.*
 - 1) Birth control pills
 - 2) Condom
 - 3) Partner's vasectomy
 - 4) Diaphragm
 - 5) Foam
 - 6) Jelly or cream
 - 7) Cervical cap
 - 8) Suppository, insert
 - 9) Today sponge
 - 10) Female condom, vaginal pouch
 - 11) IUD, Coil, Loop
 - 12) Norplant
 - 13) Depo-provera, Injectables
 - 14) Morning after pill
 - 15) Rhythm or safe period by calendar
 - 16) Safe period by temperature, or cervical mucus test, natural family planning
 - 17) Withdrawal, pulling out
 - 18) Respondent sterile
 - 19) Partner sterile
 - 20) Other method (specify)
- *Thinking again of the very first time you used a method of birth control, was it the first time you had intercourse?*

Expected Periodicity

Periodic.

Comments

Unmarried females are considered to have used a condom at first intercourse if they reported they were sexually active and partner used a condom (rubber) at their first intercourse.

Sexually experienced refers to females who had their first premarital voluntary intercourse in the past 5 years.

This objective is adapted from a measure in Healthy People 2000 objective 5.6, which tracked the proportion of sexually active, unmarried people aged 15 to 19 years who used contraception at first intercourse. This measure tracks the proportion of females aged 15 to 17 years who used a condom at first intercourse.

See Part C for a description of NSFG and Appendix A for focus area contact information.



9-10b. Condom at first intercourse: Males.

National Data Source	National Survey of Adolescent Males (NSAM), Urban Institute.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.6 (Family Planning).
Measure	Percent.
Baseline	72 (1995).
Numerator	Number of sexually experienced, unmarried males aged 15 to 17 years who used a condom at first intercourse.
Denominator	Number of sexually experienced, unmarried males aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Adolescent Males:</p> <p>[Following a question on marital status:]</p> <ul style="list-style-type: none">➤ <i>Have you ever had sexual intercourse with a female (sometimes this is called “making love,” “having sex” or “going all the way”)?</i>➤ <i>That time (the first intercourse) did you, yourself, use any method of contraceptive to prevent pregnancy or sexually transmitted disease?</i>➤ <i>What method did you use?</i><ul style="list-style-type: none">1) <i>Condom, rubber</i>2) <i>Withdrawal, pulling out</i>3) <i>Combination of methods, specify</i>4) <i>Other, specify</i>
Expected Periodicity	Periodic.
Comments	<p>Unmarried males are considered to have used a condom at first intercourse if they reported they were sexually active and used a condom (rubber) at their first intercourse.</p> <p>Sexually experienced refers to males aged 15 to 17 years who had ever had intercourse.</p>

NSFG will collect comparable data on males aged 15 to 49 years starting with data collected in 2001 and will thereby replace the NSAM for tracking of this measure.

This objective is adapted from a measure in Healthy People 2000 objective 5.6, which tracked the proportion of sexually active, unmarried people aged 15 to 19 years who used contraception at most recent intercourse. This measure tracks the proportion of males aged 15 to 17 years who used a condom at first intercourse.

See Appendix A for focus area contact information.



9-10c. Condom plus hormonal method at first intercourse: Females.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted 5.6 (Family Planning).
Measure	Percent.
Baseline	7 (1995).
Numerator	Number of sexually experienced, unmarried females aged 15 to 17 years who used a condom plus hormonal method at first intercourse.
Denominator	Number of sexually experienced, unmarried females aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 9-10a.
Expected Periodicity	Periodic.
Comments	Unmarried females are considered to have used a condom and hormonal method at first intercourse if they reported they were sexually active; partner used a condom (rubber); and they used either birth control pills, Depo-provera injectables, Norplant implants, or morning-after pills at their first intercourse.

Sexually experienced refers to females who had their first premarital voluntary intercourse in the past 5 years.

This objective is adapted from a measure in Healthy People 2000 objective 5.6, which tracked the proportion of sexually active, unmarried people aged 15 to 19 years who used both an oral contraceptive and condom at most recent intercourse. This measure tracks the proportion of females aged 15 to 17 years who used a condom plus hormonal method at first intercourse.

See Part C for a description of NSFG and Appendix A for focus area contact information.



9-10d. Condom plus hormonal method at first intercourse: Males.

National Data Source	National Survey of Adolescent Males (NSAM), Urban Institute.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.6 (Family Planning).
Measure	Percent.
Baseline	8 (1995).
Numerator	Number of sexually experienced, unmarried males aged 15 to 17 years who used a condom plus hormonal method at first intercourse.
Denominator	Number of sexually experienced, unmarried males aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 9-10b.
Expected Periodicity	Periodic.
Comments	Unmarried males are considered to have used a condom and hormonal method at first intercourse if they reported they were sexually active; used a condom (rubber); <u>and</u> their partner used either pills, Norplant, or Depo-provera at their first intercourse.

Sexually experienced refers to males aged 15 to 17 years who had ever had intercourse.

NSFG will collect comparable data on males aged 15 to 49 years starting with data collected in 2001 and will thereby replace NSAM for tracking of this measure.

This objective is adapted from a measure in Healthy People 2000 objective 5.6, which tracked the proportion of sexually active students aged 15 to 17 years who used condom and birth control pill at most recent intercourse using the Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP. This measure tracks the proportion of males aged 15 to 17 years who used a condom plus hormonal method at first intercourse.

See Appendix A for focus area contact information.



9-10e. Condom at last intercourse: Females.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 19.10a (Sexually Transmitted Diseases) (also 18.4a).
Measure	Percent.
Baseline	39 (1995).
Numerator	Number of sexually active, unmarried females aged 15 to 17 years who used a condom at last intercourse.
Denominator	Number of sexually active, unmarried females aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1995 National Survey of Family Growth:

- *What is your current marital status? Are you...*
 - 1) *Married*
 - 2) *Widowed*
 - 3) *Divorced*
 - 4) *Separated, because you and your husband are not getting along*
 - 5) *Have you never been married?*

[Following a series of questions on when sexual intercourse with a man occurred:]

- *The last time you had intercourse, did you or your partner use any method?*
- *Which methods?*
 - 1) *Birth control pills*
 - 2) *Condom*
 - 3) *Partner's vasectomy*
 - 4) *Diaphragm*
 - 5) *Foam*
 - 6) *Jelly or cream*
 - 7) *Cervical cap*
 - 8) *Suppository, insert*
 - 9) *Today sponge*
 - 10) *Female condom, vaginal pouch*
 - 11) *IUD, Coil, Loop*
 - 12) *Norplant*
 - 13) *Depo-provera, Injectables*
 - 14) *Morning after pill*
 - 15) *Rhythm or safe period by calendar*
 - 16) *Safe period by temperature, or cervical mucus test, natural family planning*
 - 17) *Withdrawal, pulling out*
 - 18) *Respondent sterile*
 - 19) *Partner sterile*
 - 20) *Other method (specify)*

Expected Periodicity

Periodic.

Comments

Unmarried females are considered to have used a condom at last intercourse if they reported they were sexually active and partner used a condom (rubber) at their last intercourse.

Sexually active refers to females who have had intercourse in the 3 months prior to interview.

This objective is adapted from a measure in Healthy People 2000 objective 19.10a, which tracked the proportion of sexually active, unmarried people aged 15 to 19 years who report their partner used a condom at last intercourse. This measure tracks the proportion of females aged 15 to 17 years who used a condom (male or female) at last intercourse.

See Part C for a description of NSFG and Appendix A for focus area contact information.



9-10f. Condom at last intercourse: Males.

National Data Source	National Survey of Adolescent Males (NSAM), Urban Institute.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 19.10b (Sexually Transmitted Diseases) (also 18.4b).
Measure	Percent.
Baseline	70 (1995).
Numerator	Number of sexually active, unmarried males aged 15 to 17 years who used a condom at last intercourse.
Denominator	Number of sexually active, unmarried males aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1995 National Survey of Adolescent Males:

[Following a question on marital status:]

- *Have you ever had sexual intercourse with a female (sometimes this is called "making love," "having sex" or "going all the way")?*
- *The last time you had intercourse with (Initials of partner) did you, yourself, use any method of contraception - that is, something to prevent pregnancy or sexually transmitted disease?*
- *What method did you use?*
 - 1) *Condom, rubber*
 - 2) *Withdrawal, pulling out*
 - 3) *Combination of methods, specify*
 - 4) *Other, specify*
- *The last time you had intercourse with (Initials of partner) did she use any contraceptive methods?*

- *What method did she use?*
- 1) *Depo-provera*
 - 2) *Diaphragm or cervical cap*
 - 3) *Douching (washing out) after intercourse*
 - 4) *Female condom*
 - 5) *Spermicidal foam/jelly/cream or suppository*
 - 6) *IUD, Coil, Loop*
 - 7) *Norplant*
 - 9) *Pill*
 - 10) *Rhythm, or safe period by calendar*
 - 11) *Sterilization*
 - 12) *Today sponge*
 - 13) *Vaginal contraceptive film or insert*
 - 14) *Combination of methods, specify*
 - 15) *Something else, specify*

Expected Periodicity Periodic.

Comments Unmarried males are considered to have used a condom at last intercourse if they reported they were sexually active and used a condom (rubber) at their last intercourse.

Sexually active refers to males who have had intercourse in the 3 months prior to interview.

NSFG will collect comparable data on males aged 15 to 49 years starting with data collected in 2001 and will thereby replace NSAM for tracking this measure.

This objective is adapted from a measure in Healthy People 2000 objective 19.10b, which tracked the proportion of sexually active, unmarried people aged 15 to 19 years who used a condom at last intercourse. This measure tracks the proportion of males aged 15 to 17 years who used a condom (rubber) or partner used a female condom (vaginal pouch) at last intercourse.

See Appendix A for focus area contact information.



9-10g. Condom plus hormonal method at last intercourse: Females.

National Data Source National Survey of Family Growth (NSFG), CDC, NCHS.

State Data Source Not identified.

Healthy People 2000 Objective	Adapted from 5.6 (Family Planning).
Measure	Percent.
Baseline	7 (1995).
Numerator	Number of sexually active, unmarried females aged 15 to 17 years who used a condom plus hormonal method at last intercourse.
Denominator	Number of sexually active, unmarried females aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 9-10e.
Expected Periodicity	Periodic.
Comments	<p>Unmarried females are considered to have used a condom and hormonal method at last intercourse if they reported they were sexually active; partner used a condom (rubber); <u>and</u> they used either birth control pills, Depo-provera injectables, Norplant implants, or morning-after pills at their last intercourse.</p> <p>Sexually active refers to females who have had intercourse in the 3 months prior to interview.</p> <p>This objective is adapted from a measure in Healthy People 2000 objective 5.6, which tracked the proportion of sexually active students aged 15 to 19 years who used oral contraceptives and condom (by partner) at most recent intercourse. This measure tracks the proportion of females aged 15 to 17 years who used a condom (male or female) plus hormonal method at last intercourse.</p> <p>See Part C for a description of NSFG and Appendix A for focus area contact information.</p>



9-10h. Condom plus hormonal method at last intercourse: Males.

National Data Source	National Survey of Adolescent Males (NSAM), Urban Institute.
State Data Source	Not identified.

Healthy People 2000 Objective	Adapted from 5.6 (Family Planning).
Measure	Percent.
Baseline	16 (1995).
Numerator	Number of sexually active, unmarried males aged 15 to 17 years who used a condom plus hormonal method at last intercourse.
Denominator	Number of sexually active, unmarried males aged 15 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with 9-10f.
Expected Periodicity	Periodic.
Comments	<p>Unmarried males are considered to have used a condom and hormonal method at last intercourse if they reported they were sexually active; used a condom (rubber); <u>and</u> their partner used either pills, Norplant, or Depo-provera at last intercourse.</p> <p>Sexually active refers to males who have had intercourse in the 3 months prior to interview.</p> <p>NSFG will collect comparable data on males aged 15 to 49 years starting with data collected in 2001 and thereby replace NSAM for tracking this measure.</p> <p>This objective is adapted from a measure in Healthy People 2000 objective 5.6, which tracked the proportion of sexually active students aged 15 to 17 years who used birth control pills (by partner) and condom at most recent intercourse using the Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP. This measure tracks the proportion of males aged 15 to 17 years who used a condom (rubber) or partner used a female condom (vaginal pouch) plus hormonal method at last intercourse.</p> <p>See Appendix A for focus area contact information.</p>



9-11. Increase the proportion of young adults who have received formal instruction before turning age 18 years on reproductive health issues, including all of the following topics: birth control methods, safer sex to prevent HIV, prevention of sexually transmitted diseases, and abstinence.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.8 (Family Planning).
Measure	Percent.
Baseline	64 (1995).
Numerator	Females aged 18 to 24 years who report having had formal instruction, before turning age 18 years, on all 4 reproductive health issues.
Denominator	Number of females aged 18 to 24 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Family Growth:</p> <p>[Question asked for each health topic:]</p> <p>➤ <i>Now I'm interested in knowing about <u>formal</u> sex education you may have had. Before you were 18, did you have any formal instruction at school, church, a community center, or some other place about...</i></p> <p>1) <i>Method of birth control?</i> 2) <i>Sexually transmitted diseases?</i> 3) <i>How to prevent AIDS using safe sex practices?</i> 4) <i>Abstinence or how to say NO to sex?</i></p>
Expected Periodicity	Periodic.
Comments	Females are considered as having received formal instruction if they report they received formal sex education before age 18 years on <u>all</u> four topics: birth control, sexually transmitted diseases, safe sex practices, and abstinence.

This objective is adapted from a measure in Healthy People 2000 objective 5.8, which tracked the proportion of people aged 10 to 18 years who have discussed human sexuality, sexual abuse, and values surrounding sexuality, with their parents and/or have received information through another parentally endorsed source, such as youth, school or religious programs. This measure tracks the proportion of females aged 18 to 24 years who have received formal, before turning age 18 years, on reproductive health issues, such as birth control methods, safer sex to prevent HIV, prevention of STDs, and abstinence.

See Part C for a description of NSFG and Appendix A for focus area contact information.



9-12. Reduce the proportion of married couples whose ability to conceive or maintain a pregnancy is impaired.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 5.3 (Family Planning).
Measure	Percent.
Baseline	13 (1995).
Numerator	Number of married females with impaired fecundity.
Denominator	Number of married females aged 15 to 44 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Family Growth:</p> <p>➤ <i>What is your current marital status? Are you...</i></p> <ol style="list-style-type: none"> 1) <i>Married,</i> 2) <i>Widowed,</i> 3) <i>Divorced,</i> 4) <i>Separated, because you and your husband are not getting along,</i> 5) <i>Have you never been married?</i>

[Following a series of questions to ALL respondents that address pregnancy, contraceptive use and periods of no sexual activity:]

- *Have you ever had both your tubes tied, cut, or removed? This procedure is often called a tubal ligation.*
- *Have you ever had a hysterectomy, that is, surgery to remove your uterus?*
- *Have you ever had both your ovaries removed?*
- *Have you ever had any other operation that makes it impossible for you to have another baby?*
- *As far as you know, are you completely sterile from this operation, that is, does it make it impossible for you to have a baby in the future?*
- *Has (name of husband/partner) ever had a vasectomy or any other operation that would make it impossible to father a baby in the future?*

[Nonsurgically sterile respondents are those who have not reported any operations for themselves, or if they are married or cohabiting, for their husbands/partners.]

[For respondents who are nonsurgically sterile:]

- *Some women are not physically able to have children. As far as you know, is it physically possible for you, yourself, to have a baby?*
- *What about (name of husband/partner)? As far as you know, is it physically impossible for him to father a baby in the future?*

[If it is physically possible:]

- *Some women are physically able to have a baby, but have difficulty getting pregnant or carrying a baby to term. As far as you know, would you, yourself, have any difficulty getting pregnant or carrying a baby to term?*
- *As far as you know, does (name of male partner) have any difficulty fathering a baby?*
- *At any time has a medical doctor ever advised you to never become pregnant (again)?*

Expected Periodicity

Periodic.

Comments

Females are considered to have impaired fecundity if they reported they are married; and neither they or their husband has had a sterilizing operation; or any one of the following:

(a) she and her husband are nonsurgically sterile and it is physically impossible for her to get pregnant or carry a baby to term, or for her husband to father a baby;

(b) it is physically difficult for her to get pregnant or carry a baby to term, or for her husband to father a baby;

(c) she has been advised by a doctor (for health reasons) not to become pregnant;

(d) she and her husband have been married for at least 36 consecutive months and have reported sexual activity without contraception for at least 36 consecutive months, and have had no pregnancies in that time period.

This objective is adapted from a measure in Healthy People 2000 objective 5.3, which tracked the prevalence of infertility. This measure tracks the proportion of married couples who are unable to conceive or maintain a pregnancy due to impaired fecundity.

See Part C for a description of NSFG and Appendix A for focus area contact information.



9-13. (Developmental) Increase the proportion of health insurance policies that cover contraceptive supplies and services.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is The Alan Guttmacher Institute (AGI).⁵

See Appendix A for focus area contact information.



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4. Fu, H.; Darroch, J.E.; Haas, T.; et al. Contraceptive Failure Rates: New Estimates from the 1995 NSFG. *Family Planning Perspectives* 31(2):56-63, 1999. <<http://www.agi-usa.org/pubs/journals/3105699.html>>
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10

Food Safety

- 10-1 Foodborne infections
 - 10-1a *Campylobacter* species
 - 10-1b *Escherichia coli* O157:H7
 - 10-1c *Listeria monocytogenes*
 - 10-1d *Salmonella* species
 - 10-1e *Cyclospora cayetanensis*
 - 10-1f Postdiarrheal hemolytic uremic syndrome
 - 10-1g Congenital *Toxoplasma gondii*
- 10-2 Outbreaks of foodborne infections
 - 10-2a *Escherichia coli* O157:H7
 - 10-2b *Salmonella* serotype Enteritidis
- 10-3 Antimicrobial resistance of *Salmonella* species
 - Resistant from humans:
 - 10-3a Fluoroquinolones
 - 10-3b Third-generation cephalosporins
 - 10-3c Gentamicin
 - 10-3d Ampicillin
 - Resistant from cattle:
 - 10-3e Fluoroquinolones
 - 10-3f Third-generation cephalosporins
 - 10-3g Gentamicin
 - 10-3h Ampicillin
 - Resistant from broilers:
 - 10-3i Fluoroquinolones
 - 10-3j Third-generation cephalosporins
 - 10-3k Gentamicin
 - 10-3l Ampicillin
 - Resistant from swine:
 - 10-3m Fluoroquinolones
 - 10-3n Third-generation cephalosporins

10-3o	Gentamicin
10-3p	Ampicillin
10-4	Food allergy deaths
10-5	Consumer food safety practices
10-6	Safe food preparation practices in retail establishments
10-7	Organophosphate pesticide exposure

10-1. Reduce infections caused by key foodborne pathogens.

10-1a. *Campylobacter* species.

National Data Source	Foodborne Disease Active Surveillance Network (FoodNet), CDC, NCID, FDA, CFSAN, USDA, FSIS, OPHS, and State agencies.
State Data Source	State Health Department reports to CDC and sites participating in FoodNet active surveillance.
Healthy People 2000 Objective	12.1 (Food and Drug Safety).
Measure	Rate per 100,000 population.
Baseline	24.6 (1997) (selected sites—see Comments).
Numerator	Number of culture-confirmed cases of illness caused by <i>Campylobacter</i> species reported to CDC.
Denominator	Number of persons.
Population Targeted	Resident population (selected sites—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>FoodNet is a collaborative effort among CDC, FDA, USDA, and participating State Health Departments. This network collects population-based surveillance data on culture-confirmed cases of foodborne illnesses from more than 300 participating clinical laboratories.</p> <p>In March 2000, the population at FoodNet sites was 25.4 million persons (10 percent of the resident population) for active surveillance of bacterial pathogens. Baseline information for bacterial infections is based on 1997 active surveillance at FoodNet sites, which included areas of California, Connecticut, Georgia, Minnesota, Oregon, and New York. Since 1997, additional counties or additional sites (New York and Maryland in 1998, Tennessee in 2000, and Colorado in 2001) have been added to the network.</p>

The data, received by CDC from the States, are based on isolates from human case specimens. The cause of the illness in many, but not all, of the cases, is a contaminated food. The denominator is from Internet site <http://www.census.gov/population/www/estimates/popest.html>.

For more information on FoodNet from the Internet, go to <http://www.cdc.gov/ncidod/dbmd/foodnet>.

See Appendix A for focus area contact information.



10-1b. *Escherichia coli* O157:H7.

National Data Source	Foodborne Disease Active Surveillance Network (FoodNet), CDC, NCID, FDA, CFSAN, USDA, FSIS, OPHS, and State agencies.
State Data Source	State Health Department reports to CDC and sites participating in FoodNet active surveillance.
Healthy People 2000 Objective	12.1 (Food and Drug Safety).
Measure	Rate per 100,000 population.
Baseline	2.1 (1997) (selected sites—see Comments).
Numerator	Number of culture-confirmed cases of illness caused by <i>Escherichia coli</i> O157:H7 reported to CDC.
Denominator	Number of persons.
Population Targeted	Resident population (selected sites—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 10-1a for more information.



10-1c. *Listeria monocytogenes*.

National Data Source	Foodborne Disease Active Surveillance Network (FoodNet), CDC, NCID, FDA, CFSAN, USDA, FSIS, OPHS, and State agencies.
State Data Source	State Health Department reports to CDC and sites participating in FoodNet active surveillance.
Healthy People 2000 Objective	12.1 (Food and Drug Safety).
Measure	Rate per 100,000 population.
Baseline	0.5 (1997) (selected sites—see Comments).
Numerator	Number of culture-confirmed cases of illness caused by <i>Listeria monocytogenes</i> reported to CDC.
Denominator	Number of persons.
Population Targeted	Resident population (selected sites—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 10-1a for more information.



10-1d. *Salmonella* species.

National Data Source	Foodborne Disease Active Surveillance Network (FoodNet), CDC, NCID, FDA, CFSAN, USDA, FSIS, OPHS, and State agencies.
State Data Source	State Health Department reports to CDC and sites participating in FoodNet active surveillance.
Healthy People 2000 Objective	12.1 (Food and Drug Safety).
Measure	Rate per 100,000 population.
Baseline	13.7 (1997) (selected sites—see Comments).

Numerator	Number of culture-confirmed cases of illness caused by <i>Salmonella</i> species reported to CDC.
Denominator	Number of persons.
Population Targeted	Resident population (selected sites—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 10-1a for more information.



10-1e. (Developmental) *Cyclospora cayetanensis*.

Comments An operational definition could not be specified at the time of publication.

A proposed national data source is FoodNet, a collaborative effort among CDC, FDA, USDA, and participating State Health Departments. Proposed State data sources are the State Health Department passive reporting to CDC and participants in FoodNet active surveillance. *Cyclospora cayetanensis* has only recently been made a nationally notifiable disease and added to Food Net surveillance. National estimates will be based on active surveillance at FoodNet sites. Final 1997 data for *Cyclospora cayetanensis* were not available at the time of publication. In 1998, the population at FoodNet sites was 24.7 million persons for active surveillance of *Cyclospora cayetanensis*.

See Appendix A for focus area contact information.



10-1f. (Developmental) Postdiarrheal hemolytic uremic syndrome.

Comments An operational definition could not be specified at the time of publication.

A proposed national data source is FoodNet, a collaborative effort among CDC, FDA, USDA, and participating State Health Departments. Proposed State data sources are the State Health Department passive reporting to CDC and participants in FoodNet active surveillance. Postdiarrheal hemolytic uremic syndrome has only recently been made a nationally notifiable disease and added to FoodNet surveillance. National estimates will be based on active surveillance at FoodNet sites. Final 1997 data for postdiarrheal hemolytic uremic syndrome were not available at the time of publication.

See Appendix A for focus area contact information.



10-1g. (Developmental) Congenital *Toxoplasma gondii*.

Comments

An operational definition could not be specified at the time of publication.

A proposed national and State data source is the National Notifiable Disease Surveillance System (NNDSS), CDC, NCID.

As occurs with other parasitic diseases, examination for toxoplasmosis is often not available or is done infrequently. Efforts are underway in the United States to make congenital toxoplasmosis a nationally notifiable disease, with serological data collection beginning in calendar year 2000. Implementation will be done in a stepwise fashion among the States. Congenital toxoplasmosis data will include neonates and their mothers.

See Appendix A for focus area contact information.



10-2. Reduce outbreaks of infections caused by key foodborne bacteria.

10-2a. *Escherichia coli* O157:H7.

National Data Source	Foodborne Disease Outbreak Surveillance System, CDC, NCID.
State Data Source	State Health Department passive reports to CDC and sites participating in FoodNet active surveillance.
Healthy People 2000 Objective	Adapted from 12.2 (Food and Drug Safety).
Measure	Number.
Baseline	22 (1997).
Numerator	Number of outbreaks of infections caused by <i>Escherichia coli</i> O157:H7 in the U.S. resident population.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A foodborne disease outbreak (FBDO) is defined as the occurrence of two or more cases of a similar illness resulting from the ingestion of a common food. FBDOs are reported to CDC on a standard reporting form. Outbreaks of known etiology are those for which laboratory evidence of a specific agent is obtained, and specified criteria are met. Most reports are received from State and local health departments; they also may be received from Federal agencies and, occasionally, from private physicians. Not included in this surveillance system are FBDOs on cruise ships; FBDOs if the food is eaten outside United States, even if the illness occurs within the United States; and if the route of transmission from the contaminated food to the infected person is indirect.</p> <p>Many foods contain several ingredients, but only one food-vehicle category is chosen for categorizing each outbreak. Therefore, the reported number of outbreaks attributed to a particular food item may not include all the reported outbreaks caused by that item. For example, homemade ice cream containing milk and eggs is listed under "ice cream" rather than "milk" or "eggs." The category "Mexican food" includes vehicles made from beef, cheese, lettuce, and other ingredients.</p>

For information on FoodNet, see Comments provided with objective 10-1a.

This objective differs from Healthy People 2000 objective 12.2, which only tracked outbreaks from *Salmonella* Enteritidis.

See Appendix A for focus area contact information.



10-2b. *Salmonella* serotype Enteritidis.

National Data Source	Foodborne Disease Outbreak Surveillance System, CDC, NCID.
State Data Source	State Health Department passive reports to CDC and sites participating in FoodNet active surveillance.
Healthy People 2000 Objective	Adapted from 12.2 (Food and Drug Safety).
Measure	Number.
Baseline	44 (1997).
Numerator	Number of outbreaks of infections caused by <i>Salmonella</i> serotype Enteritidis in the U.S. resident population.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 10-2a for more information.



10-3. Prevent an increase in the proportion of isolates of *Salmonella* species, from humans and from animals at slaughter, that are resistant to antimicrobial drugs.

10-3a. *Salmonella* from humans that are resistant to fluoroquinolones.

National Data Sources	The National Antimicrobial Resistance Monitoring System: Enteric Bacteria-Salmonella (NARMS: Enteric Bacteria), NCID, CDC; FDA, CVM; USDA, Agriculture Research Service (ARS); Foodborne Disease Active Surveillance Network (FoodNet) FDA, CDC, and USDA, FSIS.
State Data Sources	Participating local and State health departments in 17 NARMS sites—see Comments.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	0 (1997).
Numerator	Number of <i>Salmonella</i> species isolates that are resistant to fluoroquinolones.
Denominator	Number of <i>Salmonella</i> species isolates tested for resistance to fluoroquinolones.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p><i>Salmonella</i> species isolates from humans (every 10th <i>Salmonella</i> species isolate from each of 17 locations representing 32 percent of the U.S. population), will be tested for resistance to antimicrobial drugs.</p> <p>The 17 NARMS sites (including the 8 FoodNet sites) are participating local and State health departments that include California, Colorado, Connecticut, Florida, Georgia, Kansas, Los Angeles County, Massachusetts, Maryland, Minnesota, New Jersey, New York City, New York State, Oregon, Tennessee, Washington, and West Virginia. See Comments provided with objective 10-1a for more information on FoodNet.</p> <p>See Appendix A for focus area contact information.</p>



10-3b. *Salmonella* from humans that are resistant to third-generation cephalosporins.

National Data Sources	The National Antimicrobial Resistance Monitoring System: Enteric Bacteria-Salmonella (NARMS: Enteric Bacteria), NCID, CDC; FDA, CVM; USDA, ARS; Foodborne Disease Active Surveillance Network (FoodNet) FDA, CDC, and USDA, FSIS.
State Data Source	Foodborne Disease Active Surveillance Network (FoodNet), FDA, CDC, and USDA, FSIS.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	0 (1997).
Numerator	Number of <i>Salmonella</i> species isolates that are resistant to third-generation cephalosporins.
Denominator	Number of <i>Salmonella</i> species isolates tested for resistance to third-generation cephalosporins.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 10-3a for more information.



10-3c. *Salmonella* from humans that are resistant to gentamicin.

National Data Sources	The National Antimicrobial Resistance Monitoring System: Enteric Bacteria-Salmonella (NARMS: Enteric Bacteria), NCID, CDC; FDA, CVM; USDA, ARS; Foodborne Disease Active Surveillance Network (FoodNet), FDA, CDC, and USDA, FSIS.
State Data Source	Foodborne Disease Active Surveillance Network (FoodNet), CDC, FDA, USDA, and FSIS.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.

Baseline	3 (1997).
Numerator	Number of <i>Salmonella</i> species isolates that are resistant to gentamicin.
Denominator	Number of <i>Salmonella</i> species isolates tested for resistance to gentamicin.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 10-3a for more information.



10-3d. *Salmonella* from humans that are resistant to ampicillin.

National Data Sources	The National Antimicrobial Resistance Monitoring System: Enteric Bacteria-Salmonella (NARMS: Enteric Bacteria), NCID, CDC; FDA, CVM; USDA, ARS; Foodborne Disease Active Surveillance Network (FoodNet), FDA, CDC, and USDA, FSIS.
State Data Source	Foodborne Disease Active Surveillance Network (FoodNet), CDC, FDA, USDA, and FSIS.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	18 (1997).
Numerator	Number of <i>Salmonella</i> species isolates that are resistant to ampicillin.
Denominator	Number of <i>Salmonella</i> species isolates tested for resistance to ampicillin.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 10-3a for more information.



10-3e. (Developmental) *Salmonella* from cattle at slaughter that are resistant to fluoroquinolones.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source for animals at slaughter is the National Antimicrobial Resistance Monitoring System: Enteric Bacteria-Salmonella (NARMS: Enteric Bacteria), supported by surveillance and research activities of FDA, CDC, FSIS, ARS, and USDA, Animal and Plant Health Inspection Service (APHIS). Data are being collected, but were not available at the time of publication. *Salmonella* species isolates from animals at slaughter (isolates from USDA, FSIS's Hazard Analysis and Critical Control Point [HACCP] and pathogen reduction program testing for *Salmonella* species) are being tested for resistance to antimicrobial drugs.

See Appendix A for focus area contact information.



10-3f. (Developmental) *Salmonella* from cattle at slaughter that are resistant to third-generation cephalosporins.

Comments

See Comments provided with objective 10-3e for more information.



10-3g. (Developmental) *Salmonella* from cattle at slaughter that are resistant to gentamicin.

Comments

See Comments provided with objective 10-3e for more information.



10-3h. (Developmental) *Salmonella* from cattle at slaughter that are resistant to ampicillin.

Comments See Comments provided with objective 10-3e for more information.



10-3i. (Developmental) *Salmonella* from broilers at slaughter that are resistant to fluoroquinolones.

Comments See Comments provided with objective 10-3e for more information.



10-3j. (Developmental) *Salmonella* from broilers at slaughter that are resistant to third-generation cephalosporins.

Comments See Comments provided with objective 10-3e for more information.



10-3k. (Developmental) *Salmonella* from broilers at slaughter that are resistant to gentamicin.

Comments See Comments provided with objective 10-3e for more information.



10-3l. (Developmental) *Salmonella* from broilers at slaughter that are resistant to ampicillin.

Comments See Comments provided with objective 10-3e for more information.



10-3m. (Developmental) *Salmonella* from swine at slaughter that are resistant to fluoroquinolones.

Comments See Comments provided with objective 10-3e for more information.



10-3n. (Developmental) *Salmonella* from swine at slaughter that are resistant to third-generation cephalosporins.

Comments See Comments provided with objective 10-3e for more information.



10-3o. (Developmental) *Salmonella* from swine at slaughter that are resistant to gentamicin.

Comments See Comments provided with objective 10-3e for more information.



10-3p. (Developmental) *Salmonella* from swine at slaughter that are resistant to ampicillin.

Comments See Comments provided with objective 10-3e for more information.



10-4. (Developmental) Reduce deaths from anaphylaxis caused by food allergies.

Comments An operational definition could not be specified at the time of publication.

The proposed data source is the mortality component of the National Vital Statistics System. The ICD-10 assigns a code to death from food-induced anaphylaxis, although identifiers have not been assigned for various food sources, for example, peanuts, milk products, and eggs. Codes have been assigned to anaphylactic shock due to adverse food reaction in the ICD-9-CM for nonfatal anaphylactic shock due to nonpoisonous foods.

See Appendix A for focus area contact information.



10-5. Increase the proportion of consumers who follow key food safety practices.

National Data Source	Food Safety Survey (FSS), FDA, CFSAN, USDA, and FSIS.
State Data Source	See Comments.
Healthy People 2000 Objective	Adapted from 12.3 (Food and Drug Safety).
Measure	Weighted average percent.
Baseline	72 (1998).
Numerator	The sum of the average percents of consumers who report they follow each of the four key food safety practices: clean, separate, cook, and chill.
Denominator	Number of practices measured (four) among persons aged 18 years and older who prepare food (consumers).
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 Food Safety Survey:</p> <p>CLEAN</p> <p>➤ <i>Before you begin preparing food, how often do you wash your hands with soap? Would you say . . .</i></p> <ol style="list-style-type: none"> 1) <i>All of the time*</i> 2) <i>Most of the time</i> 3) <i>Some of the time, or</i> 4) <i>Rarely</i>

- *After you have cracked open raw eggs, do you usually continue cooking, or do you first rinse your hands with water, wipe them, or wash them with soap?*
 - 1) *Continue cooking*
 - 2) *Rinse or wipe hands*
 - 3) *Wash with soap**
Open-ended code:
4) *Never handle raw eggs*
- *After handling raw meat or chicken, do you usually continue cooking, or do you first rinse your hands with water, or wipe them, or wash them with soap?*
 - 1) *Continue cooking*
 - 2) *Rinse or wipe hands*
 - 3) *Wash with soap**
Open-ended code:
4) *Don't cut raw meat or chicken*
- *After handling raw fish, do you usually continue cooking, or do you first rinse your hands with water, wipe them, or wash them with soap?*
 - 1) *Continue cooking*
 - 2) *Rinse or wipe hands*
 - 3) *Wash with soap**
Open-ended code:
4) *Never handle raw fish*

SEPARATE

- *After you have used a cutting board or other surface for cutting raw meat or chicken, do you use it as it is for cutting other food to be eaten raw for the same meal, or do you first rinse it, or wipe it, or wash it with soap?*
 - 1) *Use it as it is*
 - 2) *Rinse or wipe it*
 - 3) *Wash with soap**
Open-ended codes:
4) *Wash with bleach**
5) *Use a different cutting board** 6) *Don't cut raw meat or poultry*
- *After cutting raw fish or shellfish, what do you do with the cutting board or surface? [Do you use it as it is for cutting food to be eaten raw for the same meal, or do you first rinse it, or wipe it, or wash it with soap?]*
(NOTE: MATERIAL IN BRACKETS MAY NOT NEED TO BE READ).
 - 1) *Use it as it is*
 - 2) *Rinse or wipe it*
 - 3) *Wash with soap**
Open-ended codes:
4) *Wash with bleach**
5) *Use a different cutting board**

COOK--PREFERENCE

- *In your home, are hamburgers usually served...(PROBE: IF DIFFERENT WAYS FOR DIFFERENT PEOPLE: What is the rarest degree of doneness hamburgers are served?)*
 - 1) *Rare*
 - 2) *Medium, or*
 - 3) *Well done?**Open-ended code:
 - 4) *Hamburgers are never served*
- *If (2), When you say hamburgers are usually served "medium," do you mean they are...*
 - 1) *Brown all the way through,* or*
 - 2) *Still have some pink in the middle?*
- *In the past 12 months, did you eat any of the following foods that contain raw eggs? (Did you eat. . .) (In the past 12 months, did you eat . . .)*
 - a) *Raw, homemade cookie or cake batter?*
 - b) *Homemade frosting with raw egg?*
 - c) *Caesar salad with raw egg?*
 - d) *Chocolate mousse with raw egg?*
 - e) *Homemade eggnog?*
 - f) *Homemade mayonnaise?*
 - g) *Homemade ice cream with raw egg?*
 - h) *Shakes with raw egg?*
 - i) *Homemade hollandaise sauce?*

(NOTE TO INTERVIEWERS: COMMERCIAL FROZEN OR REFRIGERATED COOKIE DOUGH IS PASTEURIZED; IT DOES NOT CONTAIN RAW EGGS EVEN BEFORE IT IS BAKED. COMMERCIAL CAKE AND COOKIE MIXES USUALLY CALL FOR ADDING RAW EGGS, SO THEY COUNT AS EATING RAW EGGS.)

- *In the past 12 months, which of the following raw foods did you eat?*
 - a) *Raw oysters*
 - b) *Sushi, ceviche (se - VEE - chay), or other raw fish*

COOK--IMPLEMENTATION

- *Thinking of your usual habits over the past year, when you prepare the following foods, how often do you use a thermometer?*
 - a) *Roasts or other large pieces of meat--how often do you use a thermometer when you cook roasts? Would you say. . .*
 - 1) *Always**
 - 2) *Often**
 - 3) *Sometimes,* or*
 - 4) *Never*Open-ended code:
 - 5) *Never cook the food*

b) Chicken parts, such as breasts or legs--how often do you use a thermometer when you cook chicken parts? Would you say. . .

- 1) Always**
- 2) Often**
- 3) Sometimes,* or*
- 4) Never*

Open-ended code:

- 5) Never cook the food*

c) How about hamburgers--how often do you use a thermometer when you cook hamburgers? Would you say. . .

- 1) Always**
- 2) Often**
- 3) Sometimes,* or*
- 4) Never*

Open-ended code:

- 5) Never cook the food*

CHILL

- *If you cook a large pot of soup, stew, or other food with meat or chicken and want to save it for the next day, when do you put the food in the refrigerator? Would it be (READ 1-3) . . .*

- 1) Immediately**
- 2) After first cooling it at room temperature, or*
- 3) After first cooling it in cold water?**

Open-ended codes:

- 4) Do not cook such foods*
- 5) Would not refrigerate it*

- *If (2): For about how long would you let it cool at room temperature? (DO NOT READ LIST)*

- 1) Less than 2 hours**
- 2) 2 hours or more*

- *How about if the soup or stew contains fish or shellfish instead of meat or chicken. If you want to save it for the next day, when do you put the food in the refrigerator? Would it be (READ 1-3) . . .*

- 1) Immediately**
- 2) After first cooling it at room temperature, or*
- 3) After first cooling it in cold water?**

Open-ended codes:

- 4) Do not cook such foods*
- 5) Would not refrigerate it*

- *If (2): For about how long would you let it cool at room temperature? (DO NOT READ LIST)*

- 1) Less than 2 hours**
- 2) 2 hours or more*

**Response is coded as safe.*

Expected Periodicity	Periodic.
Comments	<p>The key food safety practices are the four Fight BAC™ Campaign messages: 1) clean: wash hands and surfaces often; 2) separate: don't cross-contaminate; 3) cook: cook to proper temperatures; and 4) chill: refrigerate promptly.</p> <p>Calculating the estimate for this objective is a three-step process. First, the percent of consumers who have a safe response for each measure of each practice in which they have the opportunity to engage is calculated (the safe responses are indicated with an asterisk in the questionnaire above). The percents for all items that measure each practice are averaged to obtain an average percent who follow each of the four recommendations. These four average percents are summed and divided by 4 to obtain the estimate.</p> <p>For all practice estimates, the base is the number of people who engage in the behavior and who answered the question. For example, people who did not cook meat or poultry were excluded from the sample base of the questions about meat or poultry; people who did not cook fish were excluded from the practice questions about fish. The total base (excluding nonresponses) was used for the question on hand washing before preparing food and for the questions on consumption of raw foods.</p> <p>The FSS is based on 30-minute telephone interviews with consumers to determine food safety knowledge, concern level, food handling practices, perception of risk, and consumption of potentially hazardous foods by consumers. The FSS is not a regularly scheduled survey. Previous surveys have been conducted in 1988 (3,200 people surveyed), 1993 (1,620 people surveyed), and 1998 (2,001 people surveyed). Because FSS is part of the Food Safety Initiative, more frequent data collection is anticipated in the future. A fourth collection is tentatively scheduled for 2001.</p>

A proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS). In the past, the BRFSS has included an optional food safety module that has questions that are similar but not identical to FSS questions on hand washing and cutting surfaces. It has also included a question about eating hamburgers that are pink in the middle, but no question about using a food thermometer to judge when hamburgers are done. It has no question about chilling foods. The food safety module has been available since 1995. In that year, five States included the module in their BRFSS. Additional States have used the module in subsequent years, but the number of States collecting the food safety data remains low.

Note: According to a USDA study on premature browning, more than 25 percent of ground beef patties turn brown before reaching a safe internal temperature (160 degrees F).¹ Information from the CDC links eating undercooked, pink ground beef with a higher risk of illness.² Therefore, consumers should not eat ground beef patties unless a food thermometer is used to verify the temperature.^{3, 4, 5, 6}

This objective differs from Healthy People 2000 objective 12.3, which tracked refrigerating perishable foods, washing cutting boards with soap, and washing utensils with soap as individual behaviors, instead of tracking the four key food safety practices combined.

See Appendix A for focus area contact information.



10-6. (Developmental) Improve food employee behaviors and food preparation practices that directly relate to foodborne illnesses in retail food establishments.

Comments

An operational definition could not be specified at the time of publication.

The expected national data source for this objective is the Retail Food Database of Foodborne Illness Risk Factors, FDA, and CFSAN. The expected State data source will result from FDA/State cooperation in inspections.

The expected numerator will be the sum of the number of data elements (food employee behaviors and food preparation practices) directly related to foodborne illness risk that are observed to be in compliance during FDA inspections of institutions, restaurants, and retail stores.

The expected denominator will be the sum of the number of data elements (food employee behaviors and food preparation practices) directly related to foodborne illness risk that were observable (in or out of compliance) during FDA inspections of institutions, restaurants, and retail stores.

Forty-six questions, listed below from the FDA Retail Food Database of Foodborne Illness Risk Factors, will be used to obtain the data. The questions selected are critical items in the Food Code that directly relate to each risk factor group. The form was drafted for the specific purpose of collecting data regarding the occurrence at the retail level of CDC-identified risk factors associated with foodborne illness outbreaks. It was/is not intended to serve as a comprehensive, Food Code-based inspection form for food establishment inspections.

This ongoing data collection focuses on known risk factors for foodborne illness in institutions (elementary schools, hospitals, and nursing homes), restaurants (fast-food and full service), and retail stores (deli departments, meat and poultry departments, produce departments, and seafood departments of grocery stores). The following in-compliance indicators were under observation: proper holding temperatures, adequate cooking, good personal hygiene, clean equipment, and foods from safe sources.

RISK FACTOR: FOODS FROM UNSAFE SOURCE

- Approved Source
 - A. All food from Regulated Food Processing Plants/No home prepared / canned foods.*
 - B. All shellfish from National Shellfish Sanitation Program (NSSP) listed sources. No recreationally caught shellfish received or sold.*
 - C. Game, wild mushrooms harvested with approval of Regulatory Authority.*
- Receiving/Condition
 - A. Food received at proper temperatures/protected from contamination during transportation and receiving/food is safe, unadulterated.*
- Records
 - A. Shell stock tags/labels retained for 90 days from the date the container is emptied.*
 - B. As required, written documentation of parasite destruction maintained for fish products.*
 - C. CCP monitoring records maintained in accordance with HACCP plan when required.*

RISK FACTOR: INADEQUATE COOKING

- Proper Cooking Temperature per potentially hazardous food (PHF)
 - A. Raw eggs broken for immediate service cooked to 145° F for 15 seconds, eggs not prepared for immediate service cooked to 155° F for 15 seconds.*
 - B. Comminuted fish, meats, game animals 155° F for 15 seconds.*
 - C. Beef roasts, including formed roasts, are cooked to 130° F for 121 minutes or as chart specified and according to oven parameters per chart.*
 - D. Poultry; stuffed fish, meat, pasta, poultry, stuffed ratites, or stuffing containing fish, meat, poultry or ratites cooked to 165° F for 15 seconds.*
 - E. Wild game animals cooked to 165° F for 15 seconds.*
 - F. Raw animal foods cooked in microwave are rotated, stirred, covered, and heated to 165° F. Food is allowed to stand covered for 2 minutes after cooking.*
 - G. Pork, ratites, injected meats are cooked to 155° F for 15 seconds*
 - H. All other PHF cooked to 145° F for 15 seconds.*

- Rapid Reheating for Hot Holding
 - A. PHF are rapidly reheated to 165° F for 15 seconds.*
 - B. Food reheated in a microwave is heated to 165° F or higher*
 - C. Commercially processed ready-to-eat food, if reheated, held at 140° F or above.*
 - D. Remaining unsliced portions of beef roasts are reheated for hot holding using minimum oven parameters.*

RISK FACTOR: IMPROPER HOLDING

- Proper Cooling Procedures (Note any temperature above 41° F)
 - A. Cooked PHF is cooled from 140° F to 70° F within 2 hours and from 70° F to 41° F or below within 4 hours.*
 - B. Cooked PHF is cooled from 140° F to 70° F within 2 hours and from 70° F to 45° F or below within 4 hours.*
 - C. PHF (from ambient ingredients) is cooled to 41° F or below within 4 hours.*
 - D. PHF (from ambient ingredients) is cooled to 45° F or below within 4 hours.*
 - E. Foods received at a temperature according to Law are cooled to 41° F within 4 hours.*
 - F. Foods received at a temperature according to Law are cooled to 45° F within 4 hours.*
- Cold Hold (41° F/45° F)
 - A. PHF is maintained at 41° F or below, except during preparation, cooking, or cooling or when time is used as a public health control.*
 - B. PHF is maintained at 45° F or below, except during preparation, cooking, or cooling or when time is used as a public health control.*
- Hot Hold (140° F)
 - A. PHF is maintained at 140° F or above, except during preparation, cooking, or cooling or when time is used as a public health control.*
 - B. Roasts are held at a temperature of 130° F or above.*
- Time
 - A. Ready-to-eat PHF held for more than 24 hours is date marked as required (prepared on-site).*
 - B. Ready to eat PHF, held at 45° F for 4 days or 41° F for 7 days and discarded as required.*
 - C. Commercially prepared ready-to-eat PHF is date marked as required.*
 - D. When only time is used as a public health control, food is cooked and served within 4 hours as required.*

RISK FACTOR: CONTAMINATED EQUIPMENT

➤ Separation/Segregation/Protection

A. Food is protected from cross contamination by separating raw animal foods from raw, ready-to-eat food and by separating raw animal foods from cooked, ready-to-eat food.

B. Raw animal foods are separated from each other during storage, preparation, holding, and display.

C. Food is protected from environmental contamination.

D. After being served or sold to a consumer, food is not re-served.

➤ Food Contact Surfaces

A. Food contact surfaces and utensils are clean to sight and touch and sanitized before use.

RISK FACTOR: POOR PERSONAL HYGIENE

➤ Proper, Adequate Handwashing

A. Hands are clean and properly washed when and as required.

➤ Good Hygienic Practices

A. Food employees eat, drink, and use tobacco only in designated areas/do not use a utensil more than once to taste food that is sold or served/do not handle or care for animals present. Food employees experiencing persistent sneezing, coughing, or runny nose do not work with exposed food, clean equipment, utensils, linens, unwrapped single-service, or single-use articles.

➤ Prevention of Contamination From Hands

A. Employees do not contact exposed, ready-to-eat food with their bare hands.

➤ Handwash Facilities

A. Handwash facilities conveniently located and accessible for employees.

B. Handwash facilities supplied with hand cleanser/sanitary towels/hand-drying devices.

RISK FACTOR: OTHER

➤ CHEMICAL

A. No unapproved food or color additives. Sulfites are not applied to fresh fruits and vegetables intended for raw consumption.

B. Poisonous or toxic materials, chemicals, lubricants, pesticides, medicines, first aid supplies, and other personal care items properly identified, stored, and used.

C. Poisonous or toxic materials held for retail sale are properly stored.

The expected baseline data were collected by Retail Food Specialists (FDA, Office of Regulatory Affairs) through their field inspections conducted in 1998–99. Additional national benchmark data will be obtained during FDA/State inspection activities and FDA specialists' audits of programs to include incorporation of Food Code interventions.

See Appendix A for focus area contact information.



10-7. (Developmental) Reduce human exposure to organophosphate pesticides from food.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the Total Diet Study, FDA, to determine the levels of chemical contaminants, including organophosphate pesticides, present in foods. There will be continuous quarterly data collection for the Total Diet Study during the next 10 years.

The current food consumption estimates, needed for the human exposure baseline calculation, are 10 years old. During FY 2000, FDA will be updating food consumption data collection and will then be able to calculate a baseline for human exposure to selected organophosphate pesticides from food.

See Appendix A for focus area contact information.



References

1. U.S. Department of Agriculture (USDA). *FSIS/ARS Study: Premature Browning of Cooked Ground Beef*. Washington, DC: Food Safety and Inspection Service (FSIS), 1998.
2. Mead, P.S.; Finelli, L.; Lambert-Fair, M.A.; et al. Risk factors for sporadic infection with *Escherichia coli* O157:H7. *Archives of Internal Medicine* 157:204-208, 1997.
3. USDA. *FSIS Key Facts Thermometer Use for Cooking Ground Beef Patties*. Washington, DC: FSIS, 1998.
4. USDA. *Color of Cooked Ground Beef as It Relates to Doneness, Technical Information*. Washington, DC: FSIS, 1998.

5. USDA. *Thermy™: Use a Food Thermometer*. Washington, DC: FSIS, 2000.
6. USDA. *Kitchen Thermometers*. Washington, DC: FSIS, Revised April 2000.

11

Health Communication

- 11-1 Households with Internet access
- 11-2 Health literacy
- 11-3 Research and evaluation of communication programs
- 11-4 Quality of Internet health information sources
- 11-5 Centers for excellence
- 11-6 Satisfaction with health care providers' communication skills

11-1. Increase the proportion of households with access to the Internet at home.

National Data Source	Computer and Internet Supplement to the Current Population Survey (CPS), U.S. Department of Commerce, Bureau of the Census.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	26 (1998).
Numerator	Number of households with connections to the Internet by way of computer or WebTV.
Denominator	Number of households.
Population Targeted	U.S. households.
Questions Used To Obtain the National Data	<p>From the 1998 Current Population Survey:</p> <ul style="list-style-type: none">➤ <i>Is there a personal computer or laptop in this household?</i>➤ <i>Is there a WebTV in this household?</i> <p>[If “yes” to one of the above questions:]</p> <ul style="list-style-type: none">○ <i>Does anyone in this household use the Internet from home?</i> <p>[If “yes” to both of the above questions:]</p> <ul style="list-style-type: none">○ <i>Earlier you said that you have both a computer and WebTV. Does anyone in this household use either one to connect to the Internet?</i>
Expected Periodicity	Periodic.
Comments	A household was considered to have a connection to the Internet if the household responded “yes” to <u>either</u> of the last two questions above.

The 1998 baseline data were collected as part of the Computer and Internet Use Supplement to CPS; this supplement contained questions about the household in general and about those individual household members who use the Internet. The respondent was at least 15 years old, was knowledgeable about the Internet or computers, and gave proxy responses for other members of the household. It is expected that data about Internet access will be collected every 2 to 3 years, subject to funding availability.

The Census Bureau obtained data on this survey by interviewing 48,000 sample households.

See Appendix A for focus area contact information.



11-2. (Developmental) Improve the health literacy of persons with inadequate or marginal literacy skills.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source for this objective is the 2002 National Adult Literacy Survey, conducted by the U.S. States Department of Education.

See Appendix A for focus area contact information.



11-3. (Developmental) Increase the proportion of health communication activities that include research and evaluation.

Comments

An operational definition could not be specified at the time of publication.

Proposed sources of data for this objective are *Federal Register* notices, Grantmakers in Health, and the National Health Council.

See Appendix A for focus area contact information.



11-4. (Developmental) Increase the proportion of health-related World Wide Web sites that disclose information that can be used to assess the quality of the site.

Comments

An operational definition could not be specified at the time of publication.

Proposed sources of data for this objective are the Health on the Net Foundation, Health Internet Ethics (Hi-Ethics), and the Internet Healthcare Coalition.

See Appendix A for focus area contact information.



11-5. (Developmental) Increase the number of centers for excellence that seek to advance the research and practice of health communication.

Comments

An operational definition could not be specified at the time of publication.

Proposed sources of data for this objective are the American Public Health Association's Health Communication Interest Group; Society for Social Marketing; Association of Schools of Public Health (ASPH); National Cancer Institute; International Communication Association, Health Communication Division; and National Communication Association, Health Communication Division.

See Appendix A for focus area contact information.



11-6. (Developmental) Increase the proportion of persons who report that their health care providers have satisfactory communication skills.

Comments

An operational definition could not be specified at the time of publication.

Proposed sources of data for this objective include the National Committee for Quality Assurance (NCQA); the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP; the National Health Interview Survey (NHIS), CDC, NCHS; and industry surveys such as those conducted by FIND/SVP, Nielsen, and Jupiter Communications.

See Appendix A for focus area contact information.



12

Heart Disease and Stroke

Heart Disease

- 12-1 Coronary heart disease (CHD) deaths
- 12-2 Knowledge of symptoms of heart attack and importance of calling 911
- 12-3 Artery-opening therapy
- 12-4 Bystander response to cardiac arrest
- 12-5 Out-of-hospital emergency care
- 12-6 Heart failure hospitalizations
 - 12-6a 65 to 74 years
 - 12-6b 75 to 84 years
 - 12-6c 85 years and older

Stroke

- 12-7 Stroke deaths
- 12-8 Knowledge of early warning symptoms of stroke

Blood Pressure

- 12-9 High blood pressure
- 12-10 High blood pressure control
- 12-11 Action to help control blood pressure
- 12-12 Blood pressure monitoring

Cholesterol

- 12-13 Mean total blood cholesterol levels
- 12-14 High blood cholesterol levels
- 12-15 Blood cholesterol screening
- 12-16 LDL-cholesterol level in CHD patients

Heart Disease

12-1. Reduce coronary heart disease deaths.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	15.1 (Heart Disease and Stroke) (also, 1.1, 2.1, 3.1), age adjusted to the 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	208 (1998).
Numerator	Number of coronary heart disease-related deaths (ICD-9 codes 402, 410-414, 429.2).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For information on age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 15.1, which adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



12-2. (Developmental) Increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

Proposed questions to be used to obtain the national data are scheduled to be included in the 2001 NHIS.

See Appendix A for focus area contact information.



12-3. (Developmental) Increase the proportion of eligible patients with heart attacks who receive artery-opening therapy within an hour of symptom onset.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Registry of Myocardial Infarction, National Acute Myocardial Infarction Project, HCFA.

See Appendix A for focus area contact information.



12-4. (Developmental) Increase the proportion of adults aged 20 years and older who call 911 and administer cardiopulmonary resuscitation (CPR) when they witness an out-of-hospital cardiac arrest.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

Proposed questions to be used to obtain the national data are scheduled to be included in the 2001 NHIS.

See Appendix A for focus area contact information.



12-5. (Developmental) Increase the proportion of eligible persons with witnessed out-of-hospital cardiac arrest who receive their first therapeutic electrical shock within 6 minutes after collapse recognition.

Comments	An operational definition could not be specified at the time of publication. A proposed national data source is the Medical Expenditure Panel Survey (MEPS), AHRQ (formerly HCPR). See Appendix A for focus area contact information.
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12-6. Reduce hospitalizations of older adults with congestive heart failure as the principal diagnosis.

12-6a. Adults aged 65 to 74 years.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge data systems.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population.
Baseline	13.2 (1997).

Numerator	Number of discharges among adults aged 65 to 74 years with a principal diagnosis of congestive heart failure (ICD-9-CM code 428.0).
Denominator	Number of adults aged 65 to 74 years.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	Principal diagnosis is the diagnosis chiefly responsible for admission of the person to the hospital. See Part C for a description of NHDS and Appendix A for focus area contact information.



12-6b. Adults aged 75 to 84 years.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge data systems.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population.
Baseline	26.7 (1997).
Numerator	Number of discharges among adults aged 75 to 84 years with a principal diagnosis of congestive heart failure (ICD-9-CM code 428.0).
Denominator	Number of adults aged 75 to 84 years.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

See Comments provided with objective 12-6a for more information.

**12-6c. Adults aged 85 years and older.**

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge data systems.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population.
Baseline	52.7 (1997).
Numerator	Number of discharges among adults aged 85 years and older with a principal diagnosis of congestive heart failure (ICD-9-CM code 428.0).
Denominator	Number of adults aged 85 years and older.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 12-6a for more information.

**Stroke****12-7. Reduce stroke deaths.**

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.

Healthy People 2000 Objective	15.2 (Heart Disease and Stroke) (also 2.22, 3.18), age adjusted to the 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	60 (1998).
Numerator	Number of stroke deaths (ICD-9 codes 430-438).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For information on age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 15.2, which adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



12-8. (Developmental) Increase the proportion of adults who are aware of the early warning symptoms and signs of a stroke.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.</p> <p>Proposed questions to be used to obtain the national data are scheduled to be included in the 2001 NHIS.</p> <p>See Appendix A for focus area contact information.</p>
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Blood Pressure

12-9. Reduce the proportion of adults with high blood pressure.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	28 (1988–94).
Numerator	Number of adults aged 20 years and older with high blood pressure.
Denominator	Number of adults aged 20 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1988–94 National Health and Nutrition Examination Survey: ➤ <i>Are you now taking prescribed medicine?</i>
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>Adults are defined as having high blood pressure if they either: (a) have a measurement of systolic blood pressure (SBP) > 140 mmHg or diastolic blood pressure (DBP) > 90 mmHg or (b) report they are taking high blood pressure medicine.</p> <p>Measurements were taken using a sphygmomanometer according to the standardized blood pressure measurement protocols recommended by the American Heart Association.¹</p> <p>A detailed description of the procedures for blood pressure measurement in the NHANES has been published elsewhere.^{2, 3}</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For information on age adjustment, see Part A, section 5.</p>

See Part C for a description of NHANES and Appendix A for focus area contact information.



12-10. Increase the proportion of adults with high blood pressure whose blood pressure is under control.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	15.4 (Heart Disease and Stroke) (also 2.26), age adjusted to the 2000 standard population.
Measure	Percent (age adjust—see Comments).
Baseline	18 (1988–94).
Numerator	Number of adults aged 18 years and older who have been told by a doctor or other health professional to take prescribed blood pressure medicine and are now taking it and whose systolic blood pressure is less than 140 mmHg and diastolic blood pressure is less than 90 mmHg.
Denominator	Number of adults with high blood pressure aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1988–94 National Health and Nutrition Examination Survey: <ul style="list-style-type: none">➤ <i>Because of your high blood pressure/hypertension, have you ever been told by a doctor or other health professional to take prescribed medicine?</i>➤ <i>Are you now taking prescribed medicine?</i>
Expected Periodicity	Annual beginning with 1999 data.
Comments	See Comments provided with objective 12-9.



12-11. Increase the proportion of adults with high blood pressure who are taking action (for example, losing weight, increasing physical activity, or reducing sodium intake) to help control their blood pressure.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 15.5 (Heart Disease and Stroke).
Measure	Percent (age adjusted—see Comments).
Baseline	82 (1998).
Numerator	Number of adults aged 18 years and older with high blood pressure who are dieting, reducing salt or sodium intake, exercising, reducing alcohol consumption or taking high blood pressure medications.
Denominator	Number of adults with high blood pressure aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>[NUMERATOR:]</p> <ul style="list-style-type: none">➤ <i>Has a doctor or other health professional EVER advised you to go on a diet or change your eating habits to help lower your blood pressure?</i>[If yes:]<ul style="list-style-type: none">○ <i>Are you NOW following this advice?</i>➤ <i>Has a doctor or other health professional EVER advised you to cut down on salt or sodium in your diet to help lower your blood pressure?</i>[If yes:]<ul style="list-style-type: none">○ <i>Are you NOW following this advice?</i>➤ <i>Has a doctor or other health professional EVER advised you to reduce alcohol consumption to help lower your blood pressure?</i>

[If yes:]

- *Are you NOW following this advice?*

- *Has a doctor or other health professional EVER advised you to exercise to help lower your blood pressure?*

[If yes:]

- *Are you NOW following this advice?*

- *Was any medication EVER prescribed by a doctor to help lower your blood pressure?*

[If yes:]

- *Are you NOW following this advice?*

[DENOMINATOR:]

- *Were you told on two or more DIFFERENT visits that you had hypertension, also called high blood pressure?*

[If yes:]

- *Was this only during pregnancy?*

Expected Periodicity

Periodic.

Comments

People with high blood pressure are defined as those who are told on two or more occasions by a physician or other health professional that they had high blood pressure. Pregnancy-related high blood pressure is excluded.

Adults are classified as taking action to control their blood pressure if they are now following advice on any of the actions listed above: diet/change eating habits, cut down on salt intake, reduce alcohol consumption, exercise, or take medication.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For information on age adjustment, see Part A, section 5.

This objective is adapted from Healthy People 2000 objective 15.5, which tracked the proportion of people with high blood pressure who were taking medication, dieting to lose weight, cutting down on salt, and exercising to help control their blood pressure. This measure tracks the proportion of adults with high blood pressure who are reducing alcohol consumption, in addition to the other actions, to help control their blood pressure; the measure is age adjusted to the 2000 standard population.

In Healthy People 2000, a person with high blood pressure was defined as "...EVER been told by a doctor or other health professional that you had hypertension, also called high blood pressure" while in Healthy People 2010, a person is defined as "...told on two or more DIFFERENT visits that you had high blood pressure."

See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



12-12. Increase proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	15.13 (Heart Disease and Stroke), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	90 (1998).
Numerator	Number of adults aged 18 years and older who had their blood pressure measured within the preceding 2 years and can state level.
Denominator	Number of adults aged 18 years and older.

Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>➤ <i>About how long has it been since you had your blood pressure checked by a doctor or health professional?</i></p> <p>0) Never (Number) _____ Days _____ Weeks _____ Months _____ Years</p> <p>➤ <i>At that time, did the doctor or health professional say your blood pressure was high, low, or normal?</i></p> <p>1) Not told 2) High 3) Low 4) Normal 5) Borderline 6) Other - Specify _____</p>

Expected Periodicity	Periodic.
Comments	<p>An adult was considered able to state their blood pressure level if they responded high, low, normal, or borderline (categories 2-5) to the second question above.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For information on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NHIS and Appendix A for focus area contact information.</p>



Cholesterol

12-13. Reduce the mean total blood cholesterol levels among adults.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.

Healthy People 2000 Objective	15.6 (Heart Disease and Stroke) (also 2.27), age adjusted to the 2000 standard population).
Measure	Mean (age adjusted—see Comments).
Baseline	206 (1988–94).
Numerator	Sum of all cholesterol values for adults aged 20 years and older.
Denominator	Number of cholesterol measurements for adults aged 20 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual beginning with 1999 data.
Comments	<p>Total cholesterol is a combination of high-density lipoproteins (HDL), low-density lipoproteins (LDL), and very-low density lipoproteins (VLDL).</p> <p>Total blood cholesterol is measured enzymatically in a series of coupled reactions. A description of the laboratory procedures for the total cholesterol measurement in NHANES is published by NCHS.^{4, 5}</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For information on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NHANES and Appendix A for focus area contact information.</p>



12-14. Reduce the proportion of adults with high total blood cholesterol levels.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	15.7 (Heart Disease and Stroke) (also 2.25), age adjusted to the 2000 standard population.

Measure	Percent (age adjusted—see Comments).
Baseline	21 (1988–94).
Numerator	Number of adults aged 20 years and older with total blood cholesterol > 240 mg/dL.
Denominator	Number of adults aged 20 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>Total cholesterol is a combination of HDL, LDL, and VLDL.</p> <p>Total blood cholesterol is measured enzymatically in a series of coupled reactions. A description of the procedures for the total cholesterol measurement in NHANES has been published by NCHS.^{4, 5}</p> <p>Blood cholesterol levels less than 200 mg/dL are considered desirable. Levels of 240 mg/dL or above are considered high. Levels of 200-239 mg/dL are considered borderline.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For information on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NHANES and Appendix A for focus area contact information.</p>



12-15. Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

Healthy People 2000 Objective	15.14 (Heart Disease and Stroke), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	67 (1998).
Numerator	Number of adults aged 18 years and older who have had their cholesterol checked within 5 years.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>➤ <i>When was the last time that you had your blood cholesterol level checked by a doctor or health professional?</i></p> <p>0) <i>Never</i> 1) <i>A year ago or less</i> 2) <i>More than 1 year but not more than 2 years</i> 3) <i>More than 2 years but not more than 3 years</i> 4) <i>More than 3 years but not more than 5 years</i> 5) <i>Over 5 years</i></p>
Expected Periodicity	Periodic.
Comments	<p>An adult was considered as having had their blood cholesterol checked within the preceding 5 years if they responded to <u>any</u> of the categories in 1 through 4 of the question above.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For information on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.</p>



12-16. (Developmental) Increase the proportion of persons with coronary heart disease who have their LDL-cholesterol level treated to a goal of less than or equal to 100 mg/dL.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Appendix A for focus area contact information.



References

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2. HHS, NCHS. *Third National Health and Nutrition Examination Survey, 1998–1994, NHANES III Examination Data Files (CD-ROM)*. Public Use Data File Documentation No. 76200. Hyattsville, MD: CDC, 1996.
3. Frohlich, E.D.; Grim, C.; Labarthe, D.R.; et al. Recommendations for human blood pressure determination by sphygmomanometer. *Hypertension* 11:210A-222A, 1988.
4. HHS, NCHS. *Third National Health and Nutrition Examination Survey, 1998–1994, NHANES III Laboratory Data Files (CD-ROM)*. Public Use Data File Documentation No. 76200. Hyattsville, MD: CDC, 1996.
5. Gunter, E.W.; Lewis, B.G.; and Koncikowski, S.M. *Laboratory Procedures Used for the Third National Health and Nutrition Examination Survey (NHANES III), 1988–94*. HHS, Public Health Service, CDC, 1996.

13

HIV

- 13-1 New AIDS cases
- 13-2 AIDS among men who have sex with men
- 13-3 AIDS among persons who inject drugs
- 13-4 AIDS among men who have sex with men and who inject drugs
- 13-5 New HIV cases
- 13-6 Condom use
 - 13-6a Females aged 18 to 44 years
 - 13-6b Males aged 18 to 49 years
- 13-7 Knowledge of serostatus
- 13-8 HIV/AIDS counseling and education for persons in substance abuse treatment
- 13-9 HIV/AIDS, STD, and TB education in State prisons
- 13-10 HIV counseling and testing in State prisons
- 13-11 HIV testing in TB patients
- 13-12 Screening for STDs and immunization for hepatitis B
- 13-13 Treatment according to guidelines
 - Testing
 - 13-13a Viral load testing
 - 13-13b Tuberculin skin testing
 - Treatment
 - 13-13c Any antiretroviral therapy
 - 13-13d Highly active antiretroviral therapy
 - Prophylaxis
 - 13-13e *Pneumocystis carinii* pneumonia prophylaxis
 - 13-13f *Mycobacterium avium* complex prophylaxis
- 13-14 HIV-infection deaths
- 13-15 Interval between HIV infection and AIDS diagnosis
- 13-16 Interval between AIDS diagnosis and death from AIDS
- 13-17 Perinatally acquired HIV infection

13-1. Reduce AIDS among adolescents and adults.

National Data Source	HIV/AIDS Surveillance System, CDC, NCHSTP.
State Data Source	State HIV/AIDS Surveillance Programs.
Healthy People 2000 Objective	18.2 (HIV infection).
Measure	Rate per 100,000 population.
Baseline	19.5 (1998).
Numerator	Number of reported AIDS cases among adolescents and adults aged 13 years and older.
Denominator	Number of adolescents and adults aged 13 years and older.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Adult HIV/AIDS Confidential Case Report, Form 50.42A, Rev. 7/93.
Expected Periodicity	Annual.
Comments	<p>The AIDS case definition used by the HIV/AIDS Surveillance system for an AIDS case is provided by the CDC.^{1, 2, 3, 4, 5, 6, 7} Data are adjusted for reporting delay.¹</p> <p>See Part C for a description of the HIV/AIDS Surveillance System and Appendix A for focus area contact information.</p>



13-2. Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.

National Data Source	HIV/AIDS Surveillance System, CDC, NCHSTP.
State Data Source	State HIV/AIDS Surveillance Programs.
Healthy People 2000 Objective	18.2a (HIV infection).
Measure	Number of cases.
Baseline	17,847 (1998).

Numerator	Number of AIDS cases among males 13 years and older who report having sex with males after 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Adult HIV/AIDS Confidential Case Report, Form 50.42A, Rev. 7/93.
Expected Periodicity	Annual.
Comments	<p>The AIDS case definition used by the HIV/AIDS Surveillance System for an AIDS case is provided by the CDC.^{1, 2, 3, 4, 5, 6, 7} Data are adjusted for reporting delay.¹</p> <p>Case counts by date of diagnosis by exposure category have not been redistributed to adjust for cases with risk not reported or identified.</p> <p>See Part C for a description of the HIV/AIDS Surveillance System and Appendix A for focus area contact information.</p>



13-3. Reduce the number of new AIDS cases among females and males who inject drugs.

National Data Source	HIV/AIDS Surveillance System, CDC, NCHSTP.
State Data Source	State HIV/AIDS Surveillance Programs.
Healthy People 2000 Objective	18.2b (HIV infection).
Measure	Number of cases.
Baseline	12,099 (1998).
Numerator	Number of AIDS cases among persons aged 13 years and older who inject drugs.
Denominator	Not applicable.
Population Targeted	U.S. resident population.

Questions Used To Obtain the National Data	CDC Adult HIV/AIDS Confidential Case Report, Form 50.42A, Rev. 7/93.
Expected Periodicity	Annual.
Comments	See Comments provided in objective 13-2 for more information.



13-4. Reduce the number of new AIDS cases among adolescent and adult men who have sex with men and inject drugs.

National Data Source	HIV/AIDS Surveillance System, CDC, NCHSTP.
State Data Source	State HIV/AIDS Surveillance Programs.
Healthy People 2000 Objective	Adapted from 18.2 (HIV Infection).
Measure	Number of cases.
Baseline	2,122 (1998).
Numerator	Number of AIDS cases among males aged 13 years and older who inject drugs and report having sex with males after 1977, preceding the first HIV antibody test or AIDS diagnosis.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Adult HIV/AIDS Confidential Case Report, Form 50.42A, Rev. 7/93.
Expected Periodicity	Annual.
Comments	<p>The AIDS case definition used by the HIV/AIDS Surveillance system for an AIDS case is provided by the CDC.^{1, 2, 3, 4, 5, 6, 7} Data are adjusted for reporting delay.¹</p> <p>Case counts by date of diagnosis by exposure category have not been redistributed to adjust for cases with risk not reported or identified.</p>

This measure is a modification of Healthy People 2000 objective 18.2, which tracked HIV prevalence among men who have sex with men and injecting drug users separately. This measure tracks HIV prevalence among men who have sex with men and inject drugs.

See Part C for a description of the HIV/AIDS Surveillance System and Appendix A for focus area contact information.



13-5. (Developmental) Reduce the number of cases of HIV infection among adolescents and adults.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the HIV/AIDS Surveillance System, CDC, NCHSTP.

As of November 1, 1999, a total of 34 States and the U.S. Virgin Islands participate in HIV case surveillance with CDC. Combined, these areas represent approximately 42 percent of AIDS cases reported. It is expected that additional States will move to HIV case surveillance and release the data to CDC.

This objective is a modification of Healthy People 2000 objective 18.2, which tracked HIV prevalence using estimates based on data from a number of sources to derive estimates on HIV prevalence, including data from the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS (for the total population), anonymous surveys conducted in STD clinics (for men who have sex with men), seroprevalence studies (for injecting drug users), and the Survey on Childbearing Women (for females giving birth).^{8,9} This measure will provide data based on HIV case surveillance reports from the HIV/AIDS Surveillance System.

See Part C for a description of the HIV/AIDS Surveillance System and Appendix A for focus area contact information.

13-6. Increase the proportion of sexually active persons who use condoms.

13-6a. Females aged 18 to 44 years.

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 19.10 (Sexually Transmitted Diseases) (also 18.4).
Leading Health Indicator	Responsible Sexual Behavior.
Measure	Percent.
Baseline	23 (1995).
Numerator	Number of sexually active, unmarried females aged 18 to 44 years who reported using a condom at last sexual intercourse.
Denominator	Number of sexually active, unmarried females aged 18 to 44 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Family Growth:</p> <ul style="list-style-type: none">➤ <i>What is your current marital status? Are you...</i><ul style="list-style-type: none">1) <i>Married</i>2) <i>Widowed</i>3) <i>Divorced</i>4) <i>Separated, because you and your husband are not getting along</i>5) <i>Have you never been married?</i>➤ <i>The last time you had intercourse, did you or your partner use any method?</i>

[If yes:]

○ Which methods?

- 1) Birth control pills
- 2) Condom
- 3) Partner's vasectomy
- 4) Diaphragm
- 5) Foam
- 6) Jelly or cream
- 7) Cervical cap
- 8) Suppository, insert
- 9) Today sponge
- 10) Female condom, vaginal pouch
- 11) IUD, Coil, Loop
- 12) Norplant
- 13) Depo-provera, Injectables
- 14) Morning after pill
- 15) Rhythm or safe period by calendar
- 16) Safe period by temperature, or cervical mucus test, natural family planning
- 17) Withdrawal, pulling out
- 18) Respondent sterile
- 19) Partner sterile
- 20) Other method (specify)

Expected Periodicity

Periodic.

Comments

Unmarried females are considered to have used a condom at last intercourse if they reported they had never been married, were sexually active, and either used a female condom (vaginal pouch) or partner used a condom (rubber) at their last intercourse.

Sexually active refers to females who have had intercourse in the 3 months prior to interview.

This objective is adapted from a measure in Healthy People 2000 objective 19.10, which tracked the proportion of sexually active, unmarried people aged 15 to 44 years who report their partner used a condom at last intercourse. This measure tracks the proportion of females aged 18 to 44 years who used a condom (male or female) at last intercourse.

This objective is one of the measures used to track the Responsible Sexual Behavior Leading Health Indicator. See Appendix H for a complete list.

See Part C for a description of NSFG and Appendix A for focus area contact information.

13-6b. (Developmental) Males aged 18 to 49 years.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the National Survey of Family Growth (NSFG), CDC, NCHS.

The current NSFG does not collect data on males. Starting in 2001, data for males aged 18 to 49 years will be collected and can track this objective.

See Part C for a description of NSFG and Appendix A for focus area contact information.



13-7. (Developmental) Increase the number of HIV-positive persons who know their serostatus.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the HIV/AIDS Surveillance System, CDC, NCHSTP.

This measure is a modification of Healthy People 2000 objective 18.8, which tracked the percent of positive HIV tests for which people returned for counseling. This measure will track the number of HIV positive persons who know their serostatus.

See Part C for a description of the HIV/AIDS Surveillance System and Appendix A for focus area contact information.



13-8. Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support.

National Data Source Uniform Facility Data Set (UFDS), SAMHSA.

State Data Source Uniform Facility Data Set (UFDS), SAMHSA.

Healthy People 2000 Objective Adapted from 18.5 (HIV Infection).

Measure	Percent.
Baseline	58 (1997).
Numerator	Number of publicly and privately funded treatment facilities known to SAMHSA that report that they offer HIV testing; HIV/AIDS education, counseling, and support; or have special substance abuse treatment programs for persons with HIV/AIDS.
Denominator	Number of publicly and privately funded treatment facilities known to SAMHSA.
Questions Used To Obtain the National Data	<p>From the 1997 Uniform Facility Data Set:</p> <p>➤ <i>As of October 1, 1997, which of these services were being provided at this substance abuse facility?</i></p> <p>[List of options provided in three categories. Relevant responses for objective are listed below:]</p> <p><i>A) Testing [option 24: HIV/AIDS]</i> <i>B) Health Services [option: education/counseling/support]</i> <i>C) Programs for special groups [option 32: persons with AIDS]</i></p>
Expected Periodicity	Annual.
Comments	<p>A treatment facility is considered to offer HIV/STD education, counseling, and support if the facility reports it provides <u>either</u> HIV/AIDS testing, education/counseling/support health services, or programs for persons with AIDS.</p> <p>Data collection years 1998, 2000, and subsequent years will include questions that ask about HIV testing; HIV/AIDS education, counseling, and support; or special substance abuse treatment programs for persons with HIV/AIDS. The 1999 UFDS only included questions on special programs for persons with HIV.</p> <p>This objective is a modification of Healthy People 2000 objective 18.5, which tracked the proportion of injecting drug users enrolled in substance abuse treatment programs. This measure tracks the number of substance abuse treatment facilities that report offering HIV testing; HIV/AIDS education, counseling, and support; or have special substance abuse treatment programs for persons with HIV/AIDS.</p>

See Appendix A for focus area contact information.



13-9. (Developmental) Increase the number of State prison systems that provide comprehensive HIV/AIDS, sexually transmitted diseases, and tuberculosis (TB) education.

Comments

An operational definition could not be specified at time of publication.

The proposed national data source is the Biennial Survey of HIV, STD, and TB Prevention in Correctional Facilities, CDC, and NIJ.

See Appendix A for focus area contact information.



13-10. (Developmental) Increase the proportion of inmates in State prison systems who receive voluntary HIV counseling and testing during incarceration.

Comments

See Comments provided with objective 13-9 for more information.



13-11. Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV.

National Data Source	National TB Surveillance System, CDC, NCHSTP.
State Data Source	State TB Surveillance Systems.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	55 (1998).
Numerator	Number of reported TB cases among adults aged 25 to 44 years with a negative, positive or indeterminate HIV test result.
Denominator	Number of reported TB cases (based on TB case report forms) among adults aged 25 to 44 years.

Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Report of Verified Case of Tuberculosis, Form 72.9A, Rev. 5/93.
Expected Periodicity	Annual.
Comments	Numerator includes only those cases with negative, positive, and indeterminate HIV test results. See Appendix A for focus area contact information.



13-12. (Developmental) Increase the proportion of adults in publicly funded HIV counseling and testing sites who are screened for common bacterial sexually transmitted diseases (STDs) (chlamydia, gonorrhea, and syphilis) and are immunized against hepatitis B virus.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed national and State data source is the HIV Counseling and Testing System (CTS), CDC, NCHSTP.</p> <p>For STD screening, the proposed numerator is the number of HIV tests among persons aged 18 years and older visiting an STD, family planning, or prenatal/obstetric HIV counseling and testing site who also receive screening for common bacterial STDs.</p> <p>For hepatitis B immunization, the proposed numerator is the number of HIV tests among persons aged 18 years and older visiting an STD, family planning, or prenatal/obstetric HIV counseling and testing site who receive a hepatitis B vaccination, according to Advisory Committee on Immunization Practices (ACIP) recommendations.</p>
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Screening for common bacterial STDs and immunizations against hepatitis B is not feasible in all publicly funded CTS sites, which may include sites without a primary care provider on the premises. HIV counseling and testing sites providing STD, family planning, or prenatal/obstetric care will be able to offer appropriate services to populations at risk.

CTS data are from publicly funded HIV counseling and testing sites provided in a variety of settings, including freestanding HIV counseling and testing sites (which offer anonymous tests, confidential tests, or both), STD clinics, family planning clinics, prenatal clinics, drug treatment centers, and correctional facilities (including long-term and short-term detention facilities).

Data are collected and analyzed at the level of an individual test encounter, without the identity of the client. A single client can have multiple tests recorded during 1 year. Sites that only report test encounters in summary records and not individual test encounters will not be included in the analysis.

See Appendix A for focus area contact information.



13-13. Increase the proportion of HIV-infected adolescents and adults who receive testing, treatment, and prophylaxis consistent with current Public Health Service treatment guidelines.

Testing

13-13a. (Developmental) Viral load testing.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the Adult Spectrum of Disease (ASD) surveillance project, CDC, NCHSTP. ASD data represent more than 100 sites in 11 U.S. cities. ASD collects demographic, clinical, laboratory, surveillance, and other related data on HIV-infected persons aged 13 years and older. Data currently are being analyzed to measure this objective.

The proposed numerator is the number who ever received a viral load test in the past year. The proposed denominator is the number of persons who had at least one visit to a clinic participating in the ASD surveillance project.

Viral load testing is defined as the methods used to monitor HIV replication in a given sample of body fluid (usually blood). Measurements are necessary to determine risk for disease progression in an HIV-infected person and to determine when to initiate or modify antiretroviral treatment regimens.

ASD data were standardized to national AIDS surveillance data by age, race, sex, country of birth, year of AIDS diagnosis, and HIV exposure mode. Exposure modes in AIDS surveillance were redistributed to adjust for cases with risk that were not reported or identified.

ASD collects demographic, clinical, laboratory, surveillance, and other related data on HIV-infected persons aged 13 years and older.

See Appendix A for focus area contact information.



13-13b. (Developmental) Tuberculin skin testing (TST).

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the Adult Spectrum of Disease (ASD) surveillance project, CDC, NCHSTP. ASD data represent more than 100 sites in 11 U.S. cities. ASD collects demographic, clinical, laboratory, surveillance, and other related data on HIV-infected persons aged 13 years and older. Data currently are being analyzed to measure this objective.

The proposed numerator is the number of persons who ever received a tuberculin skin test. The proposed denominator is the number of persons with no history of tuberculosis who had at least one visit to a clinic participating in the ASD surveillance project.

TST is defined as the standard method for screening asymptomatic populations for infection with *M. tuberculosis*.

ASD data were standardized to national AIDS surveillance data by age, race, sex, country of birth, year of AIDS diagnosis, and HIV exposure mode. Exposure modes in AIDS surveillance were redistributed to adjust for cases with risk that were not reported or identified.

ASD collects demographic, clinical, laboratory, surveillance, and other related data on HIV-infected persons aged 13 years and older.

Data from ASD represent only persons with HIV who are in care at participating ASD facilities. Treatment interventions include viral load testing, TB skin testing, highly active antiretroviral therapy (HAART), Pneumocystis carinii pneumonia (PCP) prophylaxis, Mycobacterium avium complex (MAC) prophylaxis, and pneumococcal vaccination.

See Appendix A for focus area contact information.



Treatment

13-13c. Any antiretroviral therapy.

National Data Source	Adult Spectrum of Disease (ASD) surveillance project, CDC, NCHSTP (11 U.S. cities—see Comments).
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	80 (1997) (selected sites—Comments).
Numerator	Number of persons enrolled in the ASD surveillance project with at least one clinic visit, had a minimum cd4 cell count of less than 500, and received any antiretroviral therapy, all in the past year.

Denominator	Number of persons enrolled in the ASD surveillance project with at least one clinic visit and had a minimum cd4 cell count of less than 500 in the past year.
Population Targeted	Residents of selected sites—see Comments.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Any antiretroviral therapy is defined as any drug that inhibits the replication of HIV or destroys or brings about the destruction of a retrovirus.</p> <p>ASD data were standardized to national AIDS surveillance data by age, race, sex, country of birth, year of AIDS diagnosis, and HIV exposure mode. Exposure modes in AIDS surveillance were redistributed to adjust for cases with risk that were not reported or identified.</p> <p>ASD data represent more than 100 sites in 11 U.S. cities. ASD collects demographic, clinical, laboratory, surveillance, and other related data on HIV-infected persons aged 13 years and older.</p> <p>Data from ASD represent only persons with HIV who are in care at participating ASD facilities. Treatment interventions include viral load testing, TB skin testing, HAART, PCP prophylaxis, MAC prophylaxis, and pneumococcal vaccination.</p> <p>See Appendix A for focus area contact information.</p>



13-13d. Highly active antiretroviral therapy (HAART).

National Data Source	Adult Spectrum of Disease (ASD) surveillance project, CDC, NCHSTP (11 U.S. cities—see Comments).
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.

Baseline	40 (1997) (selected sites—see Comments).
Numerator	Number of persons enrolled in the ASD surveillance project with at least one clinic visit, had a minimum cd4 cell count of less than 500, and received any highly active antiretroviral therapy, all in the past year.
Denominator	Number of persons enrolled in the ASD surveillance project with at least one clinic visit and had a minimum cd4 cell count of less than 500 in the past year.
Population Targeted	Residents of selected sites—see Comments.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>HAART is defined as a treatment regimen for HIV infection that consists of three drugs, including two nucleoside analogue reverse transcriptase inhibitors combined with either a nonnucleoside reverse transcriptase inhibitor or a protease inhibitor.</p> <p>ASD data were standardized to national AIDS surveillance data by age, race, sex, country of birth, year of AIDS diagnosis, and HIV exposure mode. Exposure modes in AIDS surveillance were redistributed to adjust for cases with risk that were not reported or identified.</p> <p>ASD data represent more than 100 sites in 11 U.S. cities. ASD collects demographic, clinical, laboratory, surveillance, and other related data on HIV-infected persons aged 13 years and older.</p> <p>Data from ASD represent only persons with HIV who are in care at participating ASD facilities. Treatment interventions include viral load testing, TB skin testing, HAART, PCP prophylaxis, MAC prophylaxis, and pneumococcal vaccination.</p> <p>See Appendix A for focus area contact information.</p>



Prophylaxis

13-13e. *Pneumocystis carinii* pneumonia (PCP) prophylaxis.

National Data Source	Adult Spectrum of Disease (ASD) surveillance project, CDC, NCHSTP (11 U.S. cities—see Comments).
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	80 (1997) (selected sites—see Comments).
Numerator	Number of persons enrolled in the ASD surveillance project with at least one clinic visit, had no history of PCP, had a minimum cd4 cell count of less than 200, and received any appropriate PCP prophylaxis, all in the past year.
Denominator	Number of persons enrolled in the ASD surveillance project with at least one clinic visit, had no history of PCP, and had a minimum cd4 cell count of less than 200 in the past year.
Population Targeted	Residents of selected sites—see Comments.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>PCP prophylaxis is defined as medications (trimethoprim-sulfamethoxazole, dapsone, or aerosolized pentamidine) given to prevent the occurrence of PCP. The case definition of PCP is provided by CDC.⁴</p> <p>ASD data were standardized to national AIDS surveillance data for 1997 by age, race, sex, country of birth, year of AIDS diagnosis, and HIV exposure mode. Exposure modes in AIDS surveillance were redistributed to adjust for cases with risk that were not reported or identified.</p> <p>ASD data represent more than 100 sites in 11 U.S. cities. ASD collects demographic, clinical, laboratory, surveillance, and other related data on HIV-infected persons aged 13 years and older.</p>

Data from ASD represent only persons with HIV who are in care at participating ASD facilities. Treatment interventions include viral load testing, TB skin testing, HAART, PCP prophylaxis, MAC prophylaxis, and pneumococcal vaccination.

See Appendix A for focus area contact information.



13-13f. Mycobacterium avium complex (MAC) prophylaxis

National Data Source	Adult Spectrum of Disease (ASD) surveillance project, CDC, NCHSTP (11 U.S. cities—see Comments).
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	44 (1997) (selected sites—see Comments).
Numerator	Number of persons enrolled in the ASD surveillance project with at least one clinic visit, had a minimum cd4 cell count of less than 50, had no history of MAC, and received any appropriate MAC prophylaxis, all in the past year.
Denominator	Number of persons enrolled in the ASD surveillance project with at least one clinic visit, who had a minimum cd4 cell count of less than 50, and no history of MAC in the past year.
Population Targeted	Residents of selected sites—see Comments.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	MAC prophylaxis is defined as medications (rifabutin, clarithromycin, or azithromycin) given to prevent the occurrence of MAC. The case definition of MAC is provided by CDC. ⁴

ASD data were standardized to national AIDS surveillance data by age, race, sex, country of birth, year of AIDS diagnosis, and HIV exposure mode. Exposure modes in AIDS surveillance were redistributed to adjust for cases with risk that were not reported or identified.

ASD data represent more than 100 sites in 11 U.S. cities. ASD collects demographic, clinical, laboratory, surveillance, and other related data on HIV-infected persons aged 13 years and older.

Data from ASD represent only persons with HIV who are in care at participating ASD facilities. Treatment interventions include viral load testing, TB skin testing, HAART, PCP prophylaxis, MAC prophylaxis, and pneumococcal vaccination.

See Appendix A for focus area contact information.



13-14. Reduce deaths from HIV infection.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	State Vital Statistics.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 (age adjusted—see Comments).
Baseline	4.9 (1998).
Numerator	Number of deaths due to HIV infection (ICD-9 codes *042-*044).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.

Resident death data are based on information from death certificates filed in the 50 States and the District of Columbia.

See Part C for a description of NVSS and Appendix A for focus area contact information.



13-15. (Developmental) Extend the interval of time between an initial diagnosis of HIV infection and AIDS diagnosis in order to increase years of life of an individual infected with HIV.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the HIV/AIDS Surveillance System, CDC, NCHSTP.

See Part C for a description of the HIV/AIDS Surveillance System and Appendix A for focus area contact information.



13-16. (Developmental) Increase years of life of an HIV-infected person by extending the interval of time between an AIDS diagnosis and death.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the HIV/AIDS Surveillance System, CDC, NCHSTP.

See Part C for a description of the HIV/AIDS Surveillance System and Appendix A for focus area contact information.



13-17. (Developmental) Reduce new cases of perinatally acquired HIV infection.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the HIV/AIDS Surveillance System, CDC, NCHSTP.

See Part C for a description of the HIV/AIDS Surveillance System and Appendix A for focus area contact information.



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14

Immunization and Infectious Diseases

Diseases Preventable Through Universal Vaccination

- 14-1 Vaccine-preventable diseases
 - 14-1a Congenital rubella syndrome
 - 14-1b Diphtheria
 - 14-1c *Haemophilus influenzae* type b
 - 14-1d Hepatitis B
 - 14-1e Measles
 - 14-1f Mumps
 - 14-1g Pertussis
 - 14-1h Polio (wild-type virus)
 - 14-1i Rubella
 - 14-1j Tetanus
 - 14-1k Varicella (chicken pox)
- 14-2 Hepatitis B in infants and young children
- 14-3 Hepatitis B in adults and high-risk groups
 - 14-3a 19 to 24 years
 - 14-3b 25 to 39 years
 - 14-3c 40 years and older
 - 14-3d Injection drug users
 - 14-3e Heterosexually active persons
 - 14-3f Men who have sex with men
 - 14-3g Occupationally exposed workers
- 14-4 Bacterial meningitis in young children

- 14-5 Invasive pneumococcal infections
 - New invasive pneumococcal infections:
 - 14-5a Children under age 5 years
 - 14-5b Adults aged 65 years and older
 - Invasive penicillin-resistant pneumococcal infections:
 - 14-5c Children under age 5 years
 - 14-5d Adults aged 65 years and older

Diseases Preventable Through Targeted Vaccination

- 14-6 Hepatitis A
- 14-7 Meningococcal disease
- 14-8 Lyme disease

Infectious Diseases and Emerging Antimicrobial Resistance

- 14-9 Hepatitis C
- 14-10 Identification of persons with chronic hepatitis C
- 14-11 Tuberculosis
- 14-12 Curative therapy for tuberculosis
- 14-13 Treatment for high-risk persons with latent tuberculosis infection
- 14-14 Timely laboratory confirmation of tuberculosis cases
- 14-15 Prevention services for international travelers
- 14-16 Invasive early onset group B streptococcal disease
- 14-17 Peptic ulcer hospitalizations
- 14-18 Antibiotics prescribed for ear infections
- 14-19 Antibiotics prescribed for common cold
- 14-20 Hospital-acquired infections
 - Adults:
 - 14-20a Catheter-associated urinary tract infection
 - 14-20b Central line-associated bloodstream infection
 - 14-20c Ventilator-associated pneumonia
 - Infants less than or equal to 1000g:
 - 14-20d Central line-associated bloodstream infection
 - 14-20e Ventilator-associated pneumonia
- 14-21 Antimicrobial use in intensive care units

Vaccination Coverage and Strategies

- 14-22 Universally recommended vaccination of children aged 19 to 35 months
 - 14-22a 4 doses diphtheria-tetanus-pertussis (DTaP) vaccine
 - 14-22b 3 doses *Haemophilus influenzae* type b (Hib) vaccine
 - 14-22c 3 doses hepatitis B vaccine (hep B)
 - 14-22d 1 dose measles-mumps-rubella (MMR) vaccine
 - 14-22e 3 doses polio vaccine
 - 14-22f 1 dose varicella vaccine
- 14-23 Vaccination coverage for children in day care, kindergarten, and first grade
 - Day care:
 - 14-23a Diphtheria-tetanus-acellular pertussis (DTaP) vaccine
 - 14-23b Measles/mumps/rubella vaccines
 - 14-23c Polio vaccine
 - 14-23d Hepatitis B vaccine
 - 14-23e Varicella vaccine
 - K through 1st grade:
 - 14-23f Diphtheria-tetanus-pertussis (DTaP) vaccine
 - 14-23g Measles/mumps/rubella vaccines
 - 14-23h Polio vaccine
 - 14-23i Hepatitis B vaccine
 - 14-23j Varicella vaccine
- 14-24 Fully immunized young children and adolescents
 - 14-24a Children aged 19 to 35 months
 - 14-24b Adolescents aged 13 to 15 years
- 14-25 Providers who measure childhood vaccination coverage levels
 - 14-25a Public health providers
 - 14-25b Private providers
- 14-26 Children participating in population-based immunization registries
- 14-27 Vaccination coverage among adolescents
 - 14-27a Hepatitis B
 - 14-27b Measles-mumps-rubella
 - 14-27c Tetanus-diphtheria booster
 - 14-27d Varicella
- 14-28 Hepatitis B vaccination among high-risk groups
 - 14-28a Long-term hemodialysis patients
 - 14-28b Men who have sex with men
 - 14-28c Occupationally exposed workers

- 14-29 Influenza and pneumococcal vaccination of high-risk adults
 - Noninstitutionalized adults 65 years and over
- 14-29a Influenza vaccine
- 14-29b Pneumococcal vaccine
 - Noninstitutionalized high-risk adults 18 to 64 years
- 14-29c Influenza vaccine
- 14-29d Pneumococcal vaccine
 - Institutionalized adults
- 14-29e Influenza vaccine
- 14-29f Pneumococcal vaccine

Vaccine Safety

- 14-30 Adverse events from vaccinations
 - 14-30a Vaccine-associated paralytic polio
 - 14-30b Febrile seizures following pertussis vaccines
- 14-31 Active surveillance for vaccine safety

Diseases Preventable Through Universal Vaccination

14-1. Reduce or eliminate indigenous cases of vaccine-preventable diseases.

14-1a. Congenital rubella syndrome (children under age 1 year).

National Data Source	National Congenital Syndrome Registry, CDC, NCID.
State Data Source	National Congenital Syndrome Registry, CDC, NCID.
Healthy People 2000 Objective	20.1 (Immunization and Infectious Diseases).
Measure	Number.
Baseline	7 (1998).
Numerator	Number of confirmed and probable cases of congenital rubella syndrome among children under age 1 year.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Congenital Rubella Syndrome Case Report, Form 71.17, Rev. 03/97.
Expected Periodicity	Annual.
Comments	<p>A case definition for confirmed and probable cases of congenital rubella syndrome is available from CDC.¹</p> <p>See Appendix A for focus area contact information.</p>



14-1b. Diphtheria (persons under age 35 years).

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.

Healthy People 2000 Objective	Adapted from 20.1 (Immunization and Infectious Diseases).
Measure	Number.
Baseline	1 (1998).
Numerator	Number of confirmed cases of diphtheria among persons under age 35 years.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Diphtheria Worksheet.
Expected Periodicity	Annual.
Comments	<p>A case definition for confirmed cases of diphtheria is available from CDC.¹</p> <p>This objective is a modification of Healthy People 2000 objective 20.1, which tracked the number of confirmed cases of diphtheria among persons aged 25 years and under. This measure tracks the number of confirmed cases of diphtheria among persons under age 35 years.</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-1c. *Haemophilus influenzae* type b (children under age 5 years).

National Data Sources	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Active Bacterial Core Surveillance (ABCs), Emerging Infection Programs, CDC, NCID.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Adapted from 20.1 (Immunization and Infectious Diseases).
Measure	Number.
Baseline	163 (1998).

Numerator	Estimated number of all reported confirmed and probable cases of <i>Haemophilus influenzae</i> invasive disease (see Comments).
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC National Bacterial Meningitis and Bacteremia Case Report, CDC 52.15N, Rev. 02/93.
Expected Periodicity	Annual.
Comments	<p>This measure includes confirmed cases of H. influenzae type b disease and cases in which the isolate of H. influenzae is of unknown serotype (based on the eight States with specific regions under surveillance).</p> <p>A case definition for confirmed and probable cases of <i>Haemophilus influenzae</i> type b is available from CDC.¹</p> <p>This objective is a modification of Healthy People 2000 objective 20.1, which tracked the number of cases of vaccine-preventable diseases. <i>Haemophilus influenzae</i> type b was previously not included as a vaccine-preventable disease.</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-1d. Hepatitis B (persons aged 2 to 18 years).

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Adapted from 20.1 (Immunization and Infectious Diseases).
Measure	Number.
Baseline	945 (1997).

Numerator	Number of laboratory-confirmed new symptomatic hepatitis B cases among persons aged 2 to 18 years.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.
Comments	<p>A case definition for laboratory-confirmed new symptomatic cases of hepatitis B is available from CDC.¹</p> <p>This objective is a modification of Healthy People 2000 objective 20.1, which tracked the number of cases of vaccine-preventable diseases. Hepatitis B previously was not included as a vaccine-preventable disease.</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-1e. Measles (persons of all ages).

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	20.1 (Immunization and Infectious Diseases).
Measure	Number.
Baseline	74 (1998).
Numerator	Number of confirmed indigenous measles cases.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Measles Surveillance Worksheet, Rev. 05/98.

Expected Periodicity	Annual.
Comments	<p>A case definition for confirmed indigenous cases of measles is available from CDC.¹</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-1f. Mumps (persons of all ages).

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	20.1 (Immunization and Infectious Diseases).
Measure	Number.
Baseline	666 (1998).
Numerator	Number of confirmed and probably indigenous cases of mumps.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Mumps Surveillance Worksheet.
Expected Periodicity	Annual.
Comments	<p>A case definition for confirmed and probable indigenous cases of mumps is available from CDC.¹</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-1g. Pertussis (children under age 7 years).

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
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State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Adapted from 20.1 (Immunization and Infectious Diseases).
Measure	Number.
Baseline	3,417 (1998).
Numerator	Number of confirmed and probable cases of pertussis (including cases identified in outbreak settings) among children under age 7 years.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Pertussis Report, Form 71.14A, Rev. 06/86.
Expected Periodicity	Annual.
Comments	<p>A case definition for confirmed and probable cases of pertussis (including cases identified in outbreak settings) is available from CDC.¹</p> <p>This objective is a modification of Healthy People 2000 objective 20.1, which tracked the number of confirmed and probable cases of pertussis among persons of all ages. This measure tracks the number of confirmed and probable cases among children under age 7 years.</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-1h. Polio (wild-type virus) (persons of all ages).

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	20.1 (Immunization and Infectious Diseases).
Measure	Number.

Baseline	0 (1998).
Numerator	Number of indigenously acquired cases of polio (wild-type virus, excludes imported or vaccine-associated cases).
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Suspected Polio Case Worksheet.
Expected Periodicity	Annual.
Comments	<p>A case definition for indigenously acquired cases of polio (wild-type virus, excluding imported or vaccine-associated cases) is available from CDC.¹</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-1i. Rubella (persons of all ages).

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	20.1 (Immunization and Infectious Diseases).
Measure	Number.
Baseline	364 (1998).
Numerator	Number of confirmed indigenous cases of rubella.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Rubella Surveillance Worksheet.
Expected Periodicity	Annual.
Comments	A case definition for confirmed indigenous cases of rubella is available from CDC. ¹

See Part C for a description of NNDSS and
Appendix A for focus area contact information.



14-1j. Tetanus (persons under age 35 years).

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Adapted from 20.1 (Immunization and Infectious Diseases).
Measure	Number.
Baseline	14 (1998).
Numerator	Number of confirmed cases of tetanus among persons under age 35 years.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Tetanus Surveillance Case Report, Form 71.16, Rev. 06/86.
Expected Periodicity	Annual.
Comments	<p>A case definition for confirmed cases of tetanus is available from CDC.¹</p> <p>This objective is a modification of Healthy People 2000 objective 20.1, which tracked the number of confirmed cases of tetanus among persons aged 25 years and under. This measure tracks the number of confirmed cases of tetanus among persons under age 35 years.</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-1k. Varicella (chicken pox) (persons under age 18 years).

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.1 (Immunization and Infectious Diseases).
Measure	Number (4-year average).
Baseline	4 million (1990–94).
Numerator	Number of persons (all ages) who are reported to have had chicken pox (varicella) in the past year.
Denominator	Not applicable.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1999 National Health Interview Survey (see Comments):</p> <p>➤ <i>Has (<u>Sample child</u>) ever had chicken pox?</i></p> <p>[If yes:]</p> <p>○ <i>Has (<u>Sample child</u>) had chicken pox during the past 12 months?</i></p>
Expected Periodicity	Annual.
Comments	<p>A case of chicken pox is identified as any person who reported missing either more than half of 1 day of school or work due to an illness or injury or staying in bed more than half of a day due to an illness or injury and who also reported that the condition that caused the day(s) of missed school/work or day(s) of staying in bed was varicella or chicken pox. These data are adjusted from a 2-week incidence to a 12-month incidence by multiplying the estimates by a factor of 26.</p>

The baseline data for persons of all ages are a proxy measure for this objective and were calculated using the 1990–94 NHIS. NHIS was redesigned in 1997 to measure prevalence, and starting in 1999 NHIS included questions on incidence and asks if children aged under 18 years have ever had chicken pox, and if they had a case of the chicken pox/varicella in the past 12 months. This annual estimate will be the measure used to track this objective over the course of the decade.

The responses to questions on medical conditions are self-reports and are not validated. However, varicella is a distinct rash illness that is diagnosed easily by the lay public.

This objective is a modification of Healthy People 2000 objective 20.1, which tracked the number of cases of vaccine-preventable diseases. Varicella (chicken pox) previously was not included as a vaccine-preventable disease.

See Part C for a description of NHIS and Appendix A for focus area contact information.



14-2. Reduce chronic hepatitis B virus infections in infants and young children (perinatal infections).

National Data Sources	Perinatal Hepatitis B Prevention Program, CDC, NCID; National Vital Statistics System (NVSS), CDC, NCHS.
State Data Sources	State Perinatal Hepatitis B Prevention Programs; State Vital Statistics Systems.
Healthy People 2000 Objective	20.3f (Immunization and Infectious Diseases).
Measure	Number.
Baseline	1,682 (1995).
Numerator	Number of estimated chronic hepatitis B virus (HBV) infections occurring among infants and children aged 2 years and younger of HBV-infected mothers (see Comments).
Denominator	Not applicable.

Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.
Comments	<p>Using data collected by the Perinatal Hepatitis B Prevention Program and NVSS, this measure is based on the following estimation procedure:^{1, 2, 3, 4, 5}</p> <p>(1) Multiply the total births per year to HBsAg-positive women by the proportion of pregnant women screened for HBsAg and then by the proportion of infants born to identified HBsAg-positive women who receive the vaccine (this estimates the number of infants who were born to identified HBsAg-positive women and received at least one dose of vaccine).</p> <p>(2) Multiply the total number of infants who were born to HBsAg-positive women and received at least one dose of vaccine by the proportion of vaccinated infants who will remain susceptible, and add to the number of infants born to HBsAg-positive women who are not vaccinated (this estimates the number of infants born to HBsAg-positive women who remain susceptible).</p> <p>(3) Finally, multiply number of infants born to HBsAg-positive women remaining susceptible by the proportion of susceptible infants who will become infected and then by the proportion of infected infants who will remain chronically infected with HBV.</p> <p>The estimated number of births to HBV-infected mothers is derived by applying race- and ethnicity-specific estimates of the prevalence of hepatitis B surface antigen to NVSS annual natality data.</p> <p>See Part C for a description of NVSS (natality) and Appendix A for focus area contact information.</p>



14-3. Reduce hepatitis B.

Adults

14-3a. 19 to 24 years.

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Adapted from 20.3 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population.
Baseline	24.0 (1997).
Numerator	Number of estimated cases of hepatitis B among persons aged 19 to 24 years.
Denominator	Number of persons aged 19 to 24 years.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.
Comments	<p>To determine the estimated number of hepatitis B cases by year of age, the number of hepatitis B cases reported to NNDSS by year of age is multiplied by age-specific ratios of infections to reported cases and divided by the age-specific proportions of infections which are symptomatic.^{6, 7}</p> <p>To determine the estimated hepatitis B rate for a specific age group, the estimated number of cases for each year of age included in the group are added together and divided by the total population in that age group.</p> <p>This measure is a modification of its comparable Healthy People 2000 objective 20.3, which tracked all ages. This measure tracks specific age groups.</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-3b. 25 to 39 years.

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Adapted from 20.3 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population.
Baseline	20.2 (1997).
Numerator	Number of estimated cases of hepatitis B among persons aged 25 to 39 years.
Denominator	Number of persons aged 25 to 39 years.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-3 for more information.

**14-3c. 40 years and older.**

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Adapted from 20.3 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population.
Baseline	15.0 (1997).
Numerator	Number of estimated cases of hepatitis B among persons aged 40 years and older.
Denominator	Number of persons aged 40 years and older.
Population Targeted	U.S. resident population.

Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-3 for more information.



High-risk groups

14-3d. Injection drug users.

National Data Sources	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Sentinel Counties Study of Viral Hepatitis, CDC, NCID.
State Data Sources	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Viral Hepatitis Surveillance Program.
Healthy People 2000 Objective	20.3a (Immunization and Infectious Diseases).
Measure	Number.
Baseline	7,232 (1997).
Numerator	Number of estimated hepatitis B cases multiplied by the proportion of hepatitis B cases reported to the Sentinel Counties Study of Viral Hepatitis that were attributable to injection drug use.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.
Comments	To determine the estimated number of hepatitis B cases occurring in injection drug users nationwide, the estimated total number of hepatitis B cases in all age groups (for complete description of the calculation method, see objective 14-3a Comments) is multiplied by the proportion of cases reported to Sentinel Counties Study of Viral Hepatitis that occurred in injection drug users.

To obtain State-specific measures for this objective, local Viral Hepatitis Surveillance Program data are used to determine the estimated number of cases occurring in the State and the proportion attributable to injection drug use.

See Part C for a description of NNDSS and Appendix A for focus area contact information.



14-3e. Heterosexually active persons.

National Data Sources	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Sentinel Counties Study of Viral Hepatitis, CDC, NCID.
State Data Sources	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Viral Hepatitis Surveillance Program.
Healthy People 2000 Objective	20.3b (Immunization and Infectious Diseases) (also part of 19.7).
Measure	Number.
Baseline	15,225 (1997).
Numerator	Number of estimated hepatitis B cases multiplied by the proportion of new symptomatic hepatitis B cases reported to the Sentinel Counties Study of Viral Hepatitis that occurred among heterosexually active persons.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.

Comments

To determine the estimated number of hepatitis B cases occurring in heterosexually active persons nationwide, the estimated total number of hepatitis B cases in all age groups (for complete description of the calculation method, see objective 14-3a Comments) is multiplied by the proportion of cases reported to Sentinel Counties Study of Viral Hepatitis that occurred in heterosexually active persons.

To obtain State-specific measures for this objective, local Viral Hepatitis Surveillance Program data are used to determine the estimated number of cases occurring in the State and the proportion attributable to heterosexual activity.

See Part C for a description of NNDSS and Appendix A for focus area contact information.

**14-3f. Men who have sex with men.**

National Data Sources	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Sentinel Counties Study of Viral Hepatitis, CDC, NCID.
State Data Sources	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Viral Hepatitis Surveillance Program.
Healthy People 2000 Objective	20.3c (Immunization and Infectious Diseases) (also part of 19.7).
Measure	Number.
Baseline	7,232 (1997).
Numerator	Number of estimated hepatitis B cases multiplied by the proportion of hepatitis B cases reported to the Sentinel Counties Study of Viral Hepatitis that were attributable to male homosexual behavior.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.

Comments	<p>To determine the estimated number of hepatitis B cases occurring in homosexual males nationwide, the estimated total number of hepatitis B cases in all age groups (for complete description of the calculation method, see objective 14-3a Comments) is multiplied by the proportion of cases reported to Sentinel Counties Study of Viral Hepatitis that occurred in homosexual males.</p> <p>To obtain State-specific measures for this objective, local Viral Hepatitis Surveillance Program data are used to determine the estimated number of cases occurring in the State and the proportion attributable to male homosexual activity.</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>
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14-3g. Occupationally exposed workers.

National Data Sources	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Sentinel Counties Study of Viral Hepatitis, CDC, NCID.
State Data Sources	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; Viral Hepatitis Surveillance Program.
Healthy People 2000 Objective	20.3e (Immunization and Infectious Diseases) (also 10.5).
Measure	Number.
Baseline	249 (1997).
Numerator	Number of estimated hepatitis B cases multiplied by the proportion of hepatitis B cases reported to the Sentinel Counties Study of Viral Hepatitis that were attributed to occupational exposure.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.

Comments

To determine the estimated number of hepatitis B cases occurring in occupationally exposed workers nationwide, the estimated total number of hepatitis B cases in all age groups (for a complete description of the calculation method, see objective 14-3a

Comments) is multiplied by the proportion of cases reported to Sentinel Counties Study of Viral Hepatitis that occurred in occupationally exposed workers.

To obtain State-specific measures for this objective, local Viral Hepatitis Surveillance Program data are used to determine the estimated number of cases occurring in the State and the proportion attributable to occupational exposure.

See Part C for a description of NNDSS and Appendix A for focus area contact information.

**14-4. Reduce bacterial meningitis in young children.**

National Data Source	Active Bacterial Core Surveillance (ABCs), Emerging Infection Programs, CDC, NCID.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.7 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population
Baseline	13.0 (1998) (selected regions in eight States—see Comments).
Numerator	Number of laboratory culture confirmed cases with bacterial meningitis in children aged 1 to 23 months.
Denominator	Number of children aged 1 to 23 months.
Population Targeted	Resident population in the eight States with specific regions under surveillance (see Comments).
Questions Used To Obtain the National Data	CDC Active Surveillance Bacterial Meningitis and Bacteremia Case Report, Form 52.15A, Rev. 12/97.
Expected Periodicity	Annual.

Comments

A laboratory culture-confirmed case of bacterial meningitis is defined as either the isolation of *Haemophilus influenzae*, *Neisseria meningitidis*, group B *Streptococcus*, groups A *Streptococcus*, or *Streptococcus pneumoniae* from cerebral spinal fluid or a positive culture of *Haemophilus influenzae*, *Neisseria meningitidis*, group B *Streptococcus*, groups A *Streptococcus*, or *Streptococcus pneumoniae* from a different normally sterile site (blood, pleural fluid, etc.) and a clinical diagnosis of meningitis.¹

ABCs is an active and laboratory-based case surveillance system. Data are collected from acute care hospitals and reference laboratories for laboratory-confirmed cases as well as from case report forms.

Data are based on surveillance of selected regions in eight States: California, Connecticut, Georgia, Maryland, Minnesota, New York, Oregon, and Tennessee.

This measure is a modification of Healthy People 2000 objective 20.7, which tracked bacterial meningitis for all ages using the Bacterial Meningitis Surveillance System, CDC, NCID. This measure tracks bacterial meningitis for children aged 1 to 23 months using ABCs.

See Appendix A for focus area contact information.



14-5. Reduce invasive pneumococcal infections.

New invasive pneumococcal infections

14-5a. Children under age 5 years.

National Data Source	Active Bacterial Core Surveillance (ABCs), Emerging Infection Programs, CDC, NCID.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.10 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population

Baseline	76 (1997) (selected regions in eight States—see Comments).
Numerator	Number of children under age 5 years with a laboratory-confirmed invasive pneumococcal infection (see Comments) in the past 12 months.
Denominator	Number of children under age 5 years.
Population Targeted	Resident population in the eight States with specific regions under surveillance (see Comments).
Questions Used To Obtain the National Data	CDC Active Surveillance Bacterial Meningitis and Bacteremia Case Report, Form 52.15A, Rev. 12/97.
Expected Periodicity	Annual.
Comments	<p>An invasive pneumococcal infection is defined as a laboratory-confirmed isolation of <i>Streptococcus pneumoniae</i> from a normally sterile site (blood, cerebral spinal fluid, etc.).¹</p> <p>ABCs is an active and laboratory-based case surveillance system. Data are collected from acute care hospitals and reference laboratories for laboratory-confirmed cases as well as from case report forms.</p> <p>Data are based on surveillance of selected regions in eight States: California, Connecticut, Georgia, Maryland, Minnesota, New York, Oregon, and Tennessee. Data for Alaska Natives are measured by the Arctic Investigations Program, CDC, NCID.</p> <p>This measure is a modification of Healthy People 2000 objective 20.10, which tracked restricted activity days among children under age 5 years using the National Health Interview Survey (NHIS), CDC, NCHS. This objective tracks the incidence of pneumococcal infections among children under age 5 years using ABCs.</p> <p>See Appendix A for focus area contact information.</p>



14-5b. Adults aged 65 years and older.

National Data Source	Active Bacterial Core Surveillance (ABCs), Emerging Infection Programs, CDC, NCID.
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State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.10 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population
Baseline	62 (1997) (selected regions in eight States—see Comments).
Numerator	Number of adults aged 65 years and older with a laboratory-confirmed invasive pneumococcal infection (see Comments) in the past 12 months.
Denominator	Number of adults aged 65 years and older.
Population Targeted	Resident population in the eight States with specific regions under surveillance (see Comments).
Questions Used To Obtain the National Data	CDC Active Surveillance Bacterial Meningitis and Bacteremia Case Report, Form 52.15A, Rev. 12/97.
Expected Periodicity	Annual.
Comments	<p>An invasive pneumococcal infection is defined as a laboratory-confirmed isolation of <i>Streptococcus pneumoniae</i> from a normally sterile site (blood, cerebral spinal fluid, etc.).¹</p> <p>ABCs is an active and laboratory-based case surveillance system. Data are collected from acute care hospitals and reference laboratories for laboratory-confirmed cases as well as from case report forms.</p> <p>Data are based on surveillance of selected regions in eight States: California, Connecticut, Georgia, Maryland, Minnesota, New York, Oregon, and Tennessee. Data for Alaska Natives are measured by the Arctic Investigations Program, CDC, NCID.</p> <p>This measure is a modification of Healthy People 2000 objective 20.10, which tracked restricted activity days among adults aged 65 years and older years using the National Health Interview Survey (NHIS), CDC, NCHS. This objective tracks the incidence of pneumococcal infections among adults aged 65 years and older using ABCs.</p> <p>See Appendix A for focus area contact information.</p>



Invasive penicillin-resistant pneumococcal infections

14-5c. Children under age 5 years.

National Data Source	Active Bacterial Core Surveillance (ABCs), Emerging Infection Programs, CDC, NCID.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.10 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population.
Baseline	16 (1997) (selected regions in eight States—see Comments).
Numerator	Number of children under age 5 years with a laboratory-confirmed invasive penicillin-resistant pneumococcal infection (see Comments) in the past 12 months.
Denominator	Number of children under age 5 years.
Population Targeted	Resident population in the eight States with specific regions under surveillance (see Comments).
Questions Used To Obtain the National Data	CDC Active Surveillance Bacterial Meningitis and Bacteremia Case Report, Form 52.15A, Rev. 12/97.
Expected Periodicity	Annual.
Comments	<p>A laboratory-confirmed invasive penicillin-resistant pneumococcal infection is defined as the isolation of <i>Streptococcus pneumoniae</i> from a normally sterile site (blood, cerebral spinal fluid, etc.) with a penicillin minimum inhibitory concentration of greater than 2 µg/ml.</p> <p>ABCs is an active and laboratory-based case surveillance system. Data are collected from acute care hospitals and reference laboratories for laboratory-confirmed cases as well as from case report forms.</p> <p>Data are based on surveillance of selected regions in eight States: California, Connecticut, Georgia, Maryland, Minnesota, New York, Oregon, and Tennessee. Data for Alaska Natives are measured by the Arctic Investigations Program, CDC, NCID.</p>

This measure is a modification of Healthy People 2000 objective 20.10, which tracked restricted activity days among children under age 5 years using the National Health Interview Survey (NHIS), CDC, NCHS. This objective tracks the incidence of penicillin-resistant pneumococcal infections among children under age 5 years using ABCs.

See Appendix A for focus area contact information.



14-5d. Adults aged 65 years and older.

National Data Source	Active Bacterial Core Surveillance (ABCs), Emerging Infection Programs, CDC, NCID.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.10 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population.
Baseline	9 (1997) (selected regions of eight States—see Comments).
Numerator	Number of adults aged 65 years and older with a laboratory-confirmed invasive penicillin-resistant pneumococcal infection (see Comments) in the past 12 months.
Denominator	Number of adults aged 65 years and older.
Population Targeted	Resident population in the eight States with specific regions under surveillance (see Comments).
Questions Used To Obtain the National Data	CDC Active Surveillance Bacterial Meningitis and Bacteremia Case Report, Form 52.15A, Rev. 12/97.
Expected Periodicity	Annual.
Comments	A laboratory-confirmed invasive penicillin-resistant pneumococcal infection is defined as the isolation of <i>Streptococcus pneumoniae</i> from a normally sterile site (blood, cerebral spinal fluid, etc.) with a penicillin minimum inhibitory concentration of greater than 2 µg/ml.

ABCs is an active and laboratory-based case surveillance system. Data are collected from acute care hospitals and reference laboratories for laboratory-confirmed cases as well as from case report forms.

Data are based on surveillance of selected regions in eight States: California, Connecticut, Georgia, Maryland, Minnesota, New York, Oregon, and Tennessee. Data for Alaska Natives are measured by the Arctic Investigations Program, CDC, NCID.

This measure is a modification of Healthy People 2000 objective 20.10, which tracked restricted activity days among adults aged 65 years and older using the National Health Interview Survey (NHIS), CDC, NCHS. This objective tracks the incidence of penicillin-resistant pneumococcal infections among adults aged 65 years and older using ABCs.

See Appendix A for focus area contact information.



Diseases Preventable Through Targeted Vaccination

14-6. Reduce hepatitis A.

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	20.3 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population.
Baseline	11.3 (1997).
Numerator	Number of new symptomatic hepatitis A cases reported in the past 12 months.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.

Expected Periodicity	Annual.
Comments	<p>A case definition for new symptomatic cases of hepatitis A is available from CDC.¹</p> <p>See Part C for a description of NNDSS and Appendix A for focus area contact information.</p>



14-7. Reduce meningococcal disease.

National Data Sources	Active Bacterial Core Surveillance (ABCs), Emerging Infections Program Network, CDC, NCID; National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Sources	Active Bacterial Core Surveillance (ABCs), Emerging Infections Program Network, CDC, NCID; National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Adapted from 20.7 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population.
Baseline	1.3 (1997) (selected regions in eight States—see Comments).
Numerator	Number of new laboratory-confirmed meningococcal disease cases reported in past 12 months.
Denominator	Number of persons.
Population Targeted	Resident population (selected regions in eight States—see Comments).
Questions Used To Obtain the National Data	CDC National Bacterial Meningitis and Bacteremia Case Report, Form 52.15N, Rev. 02/93.
Expected Periodicity	Annual.
Comments	<p>A case definition for laboratory-confirmed cases of meningococcal disease is available from CDC.¹</p> <p>ABCs is an active and laboratory-based case surveillance system. Data are collected from acute care hospitals and reference laboratories for laboratory-confirmed cases as well as from case report forms.</p>

Data are based on surveillance of selected regions in eight States: California, Connecticut, Georgia, Maryland, Minnesota, New York, Oregon, and Tennessee.

This measure is a modification of Healthy People 2000 objective 20.10, which tracked bacterial meningitis cases using the Bacterial Meningitis Surveillance System, CDC, NCID. This measure tracks meningococcal disease (meningitis and/or meningococcemia) using both NNDSS and ABCs.

See Part C for a description of NNDSS and Appendix A for focus area contact information.



14-8. Reduce Lyme disease.

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population (5-year average).
Baseline	17.4 (1992–96) (selected States in endemic regions—see Comments).
Numerator	Number of reported cases of Lyme disease.
Denominator	Number of persons.
Population Targeted	Resident population (selected States in endemic regions—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A case definition is available from CDC.¹</p> <p>Baseline endemic regions include Connecticut, Delaware, Maryland, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, and Rhode Island.</p>

Data were unavailable by gender for Pennsylvania in 1992–93. Therefore, Pennsylvania was excluded from baseline estimates by gender.

See Part C for a description of NNDSS and Appendix A for focus area contact information.



Infectious Diseases and Emerging Antimicrobial Resistance

14-9. Reduce hepatitis C.

National Data Source	Sentinel Counties Study of Viral Hepatitis, CDC, NCID.
State Data Source	Viral Hepatitis Surveillance Program, CDC, NCID.
Healthy People 2000 Objective	20.3 (Immunization and Infectious Diseases).
Measure	Rate per 100,000 population.
Baseline	2.4 (1996).
Numerator	Number of new symptomatic hepatitis C cases.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Viral Hepatitis Case Record for Reporting of Patients With Symptomatic Acute Viral Hepatitis, Form 53.1, Rev. 06/93.
Expected Periodicity	Annual.
Comments	<p>A case definition for new symptomatic cases of hepatitis C is available from CDC.¹</p> <p>To estimate the incidence of new symptomatic hepatitis C, the incidence rate of reported non-A, non-B hepatitis per 100,000 population in the sentinel counties is multiplied by an underreporting adjustment factor of 2.4 and then by the a factor of 0.9, the proportion of non-A, non-B hepatitis that is attributable to hepatitis C virus (HCV) infection, weighted to the U.S. population. The estimates from sentinel counties are then weighted to the U.S. resident population.</p>

Because reporting of new symptomatic hepatitis C to national surveillance systems has been unreliable to date, the national incidence of hepatitis C is based on cases reported through the Sentinel Counties Study of Viral Hepatitis.

See Appendix A for focus area contact information.



14-10. (Developmental) Increase the proportion of persons with chronic hepatitis C infection identified by State and local health departments.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health and Nutrition Examination Survey, CDC, NCHS. A proposed State data source are the State and local health departments.

Establishment of registries for HCV-infected persons will be needed to determine the cumulative number of HCV-infected persons reported to State and local health departments.

See Appendix A for focus area contact information.



14-11. Reduce tuberculosis.

National Data Source National TB Surveillance System, CDC, NCHSTP.

State Data Source State TB Surveillance Systems.

Healthy People 2000 Objective 20.4 (Immunization and Infectious Diseases).

Measure Rate per 100,000 population.

Baseline 6.8 (1998).

Numerator Number of confirmed new cases of tuberculosis reported to CDC by local health departments in all 50 States and the District of Columbia.

Denominator Number of persons.

Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Report of Verified Case of Tuberculosis, Form 72.9A, Rev. 05/93, and Forms 72.9B-C, Rev. 12/92.
Expected Periodicity	Annual.
Comments	<p>A confirmed case definition for tuberculosis is available from CDC.¹</p> <p>Data for this measure are also included in Reported Tuberculosis in the United States, 1998.⁸</p> <p>See Appendix A for focus area contact information.</p>



14-12. Increase the proportion of all tuberculosis patients who complete curative therapy within 12 months.

National Data Source	National TB Surveillance System, CDC, NCHSTP.
State Data Source	State TB Surveillance Systems.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	74 (1996).
Numerator	Number of persons with confirmed new cases of tuberculosis who were alive at diagnosis, with an initial drug regimen of one or more drugs prescribed, who did not die during therapy, and who completed curative therapy within 12 months of diagnosis.
Denominator	Number of persons with confirmed new cases of tuberculosis who were alive at diagnosis, with an initial drug regimen of one or more drugs prescribed, and who did not die during therapy.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Report of Verified Case of Tuberculosis, Form 72.9A, Rev. 05/93, and Forms 72.9B-C, Rev. 12/92.
Expected Periodicity	Annual.
Comments	A confirmed case definition for tuberculosis is available from CDC. ¹

Data for this measure are also included in Reported Tuberculosis in the United States, 1998.⁸

See Appendix A for focus area contact information.



14-13. Increase the proportion of contacts and other high-risk persons with latent tuberculosis infection who complete a course of treatment.

National Data Source	Aggregate Reports for TB Reports Evaluation, CDC, NCHSTP.
State Data Source	State TB Surveillance Systems.
Healthy People 2000 Objective	Adapted from 20.18 (Immunization and Infectious Diseases).
Measure	Percent.
Baseline	62 (1997).
Numerator	Number of contacts, tuberculin converters, and others placed on treatment for latent TB infection who complete the recommended therapy.
Denominator	Number of contacts, tuberculin converters, and other persons placed on treatment for latent TB infection.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Report of Verified Case of Tuberculosis, Form 72.9A, Rev. 05/93, and Forms 72.9B-C, Rev. 12/92; CDC Tuberculosis Program Management Report, Completion of Preventive Therapy, Form 72.21 (formerly 5.63), Rev. 01/97.
Expected Periodicity	Annual.
Comments	A confirmed case definition for tuberculosis is available from CDC. ¹

High-risk persons are defined by the CDC Tuberculosis Program Management Report form. "Contacts" are all persons who have recently shared the same air space with a person who has pulmonary tuberculosis. "Recent tuberculin converters" are those who have had a tuberculin skin test conversion within the past 2 years exclusive of those persons eligible for the contact category. "Others placed on treatment for latent TB infection" include all other persons started on therapy for latent tuberculosis infection during the time period.

See Appendix A for focus area contact information.



14-14. Reduce the average time for a laboratory to confirm and report tuberculosis cases.

National Data Source	Survey of State Public Health Laboratories, CDC, NCHSTP.
State Data Source	Survey of State Public Health Laboratories, CDC, NCHSTP.
Healthy People 2000 Objective	Not applicable.
Measure	Mean number of days per State health laboratory.
Baseline	21 (1996).
Numerator	Sum of the mean number of days (from receipt of an initial diagnostic specimen from a suspected case to confirming it as coming from a case of tuberculosis among the most rapidly confirmed 75 percent of laboratory-confirmed tuberculosis cases), as reported by all participating State health laboratories.
Denominator	Sum of the number of all the cases of tuberculosis confirmed by each State health laboratory, as reported by all participating State health laboratories, multiplied by a factor of 0.75.
Questions Used To Obtain the National Data	From the 1996 National Survey of State Public Health Laboratories:

[NUMERATOR:]

- *For the most rapidly confirmed 75% of the laboratory-confirmed tuberculosis cases, what was the mean number of days or hours from receipt of an initial diagnostic specimen from a suspected case to confirming it as coming from a case of tuberculosis*
- _____ mean number of days (hours) to confirm 75% of tuberculosis cases

[DENOMINATOR:]

- *How many cases of tuberculosis were confirmed by your laboratory?*
- _____ number of laboratory-confirmed tuberculosis cases

Expected Periodicity

Periodic.

Comments

The mean number of days was calculated by each State health laboratory by summing the mean number of days it takes to confirm 75 percent of the most rapidly confirmed cases out of all its laboratory-confirmed cases of tuberculosis and was then divided by the total number of confirmed cases that constituted the 75 percent most rapidly confirmed cases. This mean was then summed with all participating State health laboratories and divided by the number of laboratories.^{9, 10}

See Appendix A for focus area contact information.



14-15. (Developmental) Increase the proportion of international travelers who receive recommended prevention services when traveling in areas of risk for select infectious diseases: hepatitis A, malaria, and typhoid.

Comments

An operational definition could not be specified at the time of publication.

This objective is a modification of Healthy People 2000 objective 20.6, which tracked the number of cases of typhoid fever, hepatitis A, and malaria using, respectively, the Typhoid Surveillance System, CDC NCID; Sentinel Counties of Acute Viral Hepatitis, CDC, NCID and NNDSS, CDC, EPO; and Malaria Surveillance System, CDC, NCID.

The proposed measure will track the proportion of travelers receiving the recommended prevention services. A proposed data source is the *Abstract of International Travel to and from the United States*, Department of Commerce. The number of international travelers from the United States has increased an average of 3 percent a year for the past decade. Recognition of such increases will be factored into the analysis for denominator data.

Travelers to risk areas will be defined as those travelers to moderate and high prevalence areas of hepatitis A as identified in the most recent edition of CDC's Health Information for International Travel. Travelers who received either hepatitis A vaccine or immune globulin according to current Advisory Committee on Immunization Practices (ACIP) recommendations will be considered protected.

An appropriate prescription of antimalarial prophylaxis medications constitutes recommended preventive services for this disease. Risk areas will be identified by referencing the malaria section in the most recent edition of Health Information for International Travel.

Travelers to risk countries will be considered those persons who visit countries with intermediate to high endemicity for typhoid fever infection. Three vaccines currently are available in the United States for prevention of typhoid fever, and all these are considered adequate protection. If new vaccines are approved and identified by CDC as efficacious, they also could be included.

See Appendix A for focus area contact information.



14-16. Reduce invasive early onset group B streptococcal disease.

National Data Sources	Active Bacterial Core Surveillance (ABCs), Emerging Infections Program Network, CDC, NCID; National Vital Statistics System, CDC, NCHS.
State Data Source	Not identified.

Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 live births.
Baseline	1.0 (1996) (selected regions in eight States).
Numerator	Number of newborns aged 0 to 6 days with a newly reported laboratory-confirmed case of early-onset group B streptococcal disease in the past 12 months.
Denominator	Number of live births.
Population Targeted	Resident population (selected regions in eight States) (see Comments).
Questions Used To Obtain the National Data	CDC Active Surveillance Bacterial Meningitis and Bacteremia Case Report, Form 52.15A, Rev. 12/97.
Expected Periodicity	Annual.
Comments	<p>A laboratory-confirmed case of group B <i>Streptococcus</i> is defined as either the isolation of group B <i>Streptococcus</i> from cerebrospinal fluid or a positive culture of group B <i>Streptococcus</i> from a different normally sterile site (blood, pleural fluid, etc.) in a newborn aged 0 to 6 days in the surveillance area.</p> <p>ABCs is an active and laboratory-based case surveillance system. Data are collected from acute care hospitals and reference laboratories for laboratory-confirmed cases as well as from case report forms.</p> <p>Data are based on surveillance of selected regions in eight States: California, Connecticut, Georgia, Maryland, Minnesota, New York, Oregon, and Tennessee.</p> <p>More information on laboratory-based surveillance for meningococcal disease (including group B streptococcal disease) is provided by CDC.¹¹</p> <p>See Appendix A for focus area contact information.</p>



14-17. Reduce hospitalizations caused by peptic ulcer disease in the United States.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge data systems.
Healthy People 2000 Objective	Adapted from 17.21 (Diabetes and Chronic Disabling Conditions).
Measure	Rate per 100,000 population.
Baseline	71 (1998).
Numerator	Number of hospitalizations with uncomplicated ulcers or ulcers complicated by bleeding or perforation as the principal diagnosis (ICD-9-CM codes 531-534).
Denominator	Number of persons.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Principal diagnosis is the diagnosis chiefly responsible for admission of the person to the hospital.</p> <p>This measure is a modification from its comparable Healthy People 2000 objective 17.21, which tracked the proportion of persons in the U.S. civilian, noninstitutionalized population who reported having an ulcer in the past 12 months, using self-reported conditions, from the National Health Interview Survey (NHIS), CDC, NCHS. This measure tracks the number of hospitalizations with uncomplicated ulcers or ulcers complicated by bleeding or perforation as the first-listed diagnosis (ICD-9-CM codes 531-534) in the U.S. civilian population using NHDS.</p> <p>See Appendix A for focus area contact information.</p>



14-18. Reduce the number of courses of antibiotics for ear infections for young children.

National Data Sources	National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.9 (Immunization and Infectious Diseases).
Measure	Rate per 100 children (2-year average).
Baseline	108 (1996–97).
Numerator	Number of antibiotic courses ordered, supplied, administered, or continued at a specific visit for children under age 5 years diagnosed with an ear infection (ICD-9-CM codes 381.0, 381.4, 382.0, 382.4, or 382.9).
Denominator	Number of children under age 5 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1996–97 National Ambulatory Medical Care Survey/National Hospital Ambulatory Medical Care Survey:</p> <ul style="list-style-type: none"> ➤ <i>Physician's diagnosis for this visit. As specifically as possible, list diagnoses related to this visit including chronic conditions (e.g. depression, obesity, asthma, etc.).</i> <ol style="list-style-type: none"> 1. Primary diagnosis: _____ 2. Other: _____ 3. Other: _____ ➤ <i>Medications/injections. List names of up to 6 medications that were ordered, supplied, administered, or continued during this visit. Include L and OTC medications, immunizations, allergy shots, and anesthetics.</i> <ul style="list-style-type: none"> <input type="checkbox"/> None <p><i>Check the box next to drug name if it is from the patient's insurance formulary list.</i></p> <p><i>Check here if NO drugs are from a formulary list</i></p> <ol style="list-style-type: none"> <input type="checkbox"/> 1. _____ <input type="checkbox"/> 2. _____ <input type="checkbox"/> 3. _____ <input type="checkbox"/> 4. _____ <input type="checkbox"/> 5. _____ <input type="checkbox"/> 6. _____

Expected Periodicity	Annual.
Comments	<p>The number of courses of antibiotics for ear infections among young children (and for the sole diagnosis of the common cold among all ages) are the sum of cases reported by NAMCS and NHAMCS that are listed as any diagnosis (including the primary diagnosis).</p> <p>NAMCS and NHAMCS are being redesigned in 2000, and modifications to survey questions on medications may affect the trend of this measure.</p> <p>This objective differs from Healthy People 2000 objective 20.9, which tracked restricted activity days due to ear infections among children aged 4 years and under using the National Health Interview Survey (NHIS), CDC, NCHS.</p> <p>See Part C for descriptions of NAMCS and NHAMCS and Appendix A for focus area contact information.</p>



14-19. Reduce the number of courses of antibiotics prescribed for the sole diagnosis of the common cold.

National Data Sources	National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population (2-year average).
Baseline	2,535 (1996–97).
Numerator	Number of antibiotic courses ordered, supplied, administered, or continued at a specific visit for persons diagnosed with the common cold (ICD-9-CM codes 460.0, 465, or 472.0).
Denominator	Number of persons.
Population Targeted	U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 14-18.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-18 for more information.



14-20. Reduce hospital-acquired infections in intensive care unit patients.

Intensive care unit patients

14-20a. Catheter-associated urinary tract infection.

National Data Source	National Nosocomial Infections Surveillance (NNIS) System, CDC, NCID.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.5 (Immunization and Infectious Diseases).
Measure	Rate per 1,000 days' use.
Baseline	5.9 (1998).
Numerator	Number of hospital-acquired indwelling urinary catheter-associated urinary tract infections among intensive care unit patients.
Denominator	Number of indwelling urinary catheter-days among intensive care unit patients.
Population Targeted	Acute care general hospital patient population.
Questions Used To Obtain the National Data	Numerator: CDC National Nosocomial Infections Surveillance System Infection Worksheet, Form 57.58D, Rev. 01/98. Denominator: CDC National Nosocomial Infections Surveillance System Adult and Pediatric Intensive Care Unit (ICU) Monthly Report Form, Form 57.58B, Rev. 01/98.
Expected Periodicity	Annual.
Comments	The 1998 point estimate represents an aggregate of data from all types of ICUs during January 1992 through March 1999.

Data may not be representative of all U.S. hospitals. For each year of data collection, not all participating hospitals are represented.

Detailed surveillance protocols used in NNIS System, including all data field definitions, can be found in the *NNIS Manual*, May 1999 (available by request to NNIS hospitals, State health departments, and international ministries of health).¹² Definitions of infections and key data fields and a description of the protocols are available.^{13, 14}

This objective is a modification of Healthy People 2000 objective 20.5, which tracked the urinary tract infection rates per 1,000 device days among patients by specific type of intensive care unit categories (surgical ICUs, medical ICUs, and pediatric ICUs). This measure tracks catheter-associated urinary tract infection rates per 1,000 days' use among patients in all ICUs.

See Appendix A for focus area contact information.



14-20b. Central line-associated bloodstream infection.

National Data Source	National Nosocomial Infections Surveillance (NNIS) System, CDC, NCID.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.5 (Immunization and Infectious Diseases).
Measure	Rate per 1,000 days' use.
Baseline	5.3 (1998).
Numerator	Number of hospital-acquired central line-associated bloodstream infections among intensive care unit patients.
Denominator	Number of central line-days among intensive care unit patients.
Population Targeted	Acute care general hospital patient population.

Questions Used To Obtain the National Data

Numerator: CDC National Nosocomial Infections Surveillance System Infection Worksheet, Form 57.58D, Rev. 01/98.

Denominator: CDC National Nosocomial Infections Surveillance System Adult and Pediatric Intensive Care Unit (ICU) Monthly Report Form, Form 57.58B, Rev. 01/98, and CDC National Nosocomial Infections Surveillance Infection Worksheet, Forms 57.58 B and D, Rev. 01/98.

Expected Periodicity

Annual.

Comments

The 1998 point estimate represents an aggregate of data from all types of ICUs from January 1992 through March 1999.

Data may not be representative of all U.S. hospitals. For each year of data collection, not all participating hospitals are represented.

Detailed surveillance protocols used in NNIS System, including all data field definitions, can be found in the *NNIS Manual*, May 1999 (available by request to *NNIS hospitals*, State health departments, and international ministries of health).¹² Definitions of infections and key data fields and a description of the protocols are available.^{13, 14}

This objective is a modification of Healthy People 2000 objective 20.5, which tracked bloodstream infection rates per 1,000 device days among patients by specific type of intensive care unit categories (surgical ICUs, medical ICUs, and pediatric ICUs). This measure tracks central line-associated bloodstream infection rates per 1,000 days' use among patients in all ICUs.

See Appendix A for focus area contact information.



14-20c. Ventilator-associated pneumonia.

National Data Source

National Nosocomial Infections Surveillance (NNIS) System, CDC, NCID.

State Data Source

Not identified.

Healthy People 2000 Objective	Adapted from 20.5 (Immunization and Infectious Diseases).
Measure	Rate per 1,000 days' use.
Baseline	11.1 (1998).
Numerator	Number of hospital-acquired ventilator-associated pneumonia infections among intensive care unit patients.
Denominator	Number of ventilator-days among intensive care unit patients.
Population Targeted	Acute care general hospital patient population.
Questions Used To Obtain the National Data	<p>Numerator: CDC National Nosocomial Infections Surveillance System Infection Worksheet, Form 57.58D, Rev. 01/98.</p> <p>Denominator: CDC National Nosocomial Infections Surveillance System Adult and Pediatric Intensive Care Unit (ICU) Monthly Report Form, Form 57.58B, Rev. 01/98.</p>
Expected Periodicity	Annual.
Comments	<p>The 1998 point estimate represents an aggregate of data from all types of ICUs from January 1992 through March 1999.</p> <p>Data may not be representative of all U.S. hospitals. For each year of data collection, not all participating hospitals are represented.</p> <p>Detailed surveillance protocols used in NNIS System, including all data field definitions, can be found in the <i>NNIS Manual</i>, May 1999 (available by request to NNIS hospitals, State health departments, and international ministries of health).¹² Definitions of infections and key data fields and a description of the protocols are available.^{13, 14}</p> <p>This objective is a modification of Healthy People 2000 objective 20.5, which tracked pneumonia infection rates per 1,000 device days among patients by specific type of intensive care unit categories (surgical ICUs, medical ICUs, and pediatric ICUs). This measure tracks ventilator-associated pneumonia infection rates per 1,000 days' use among all ICUs.</p> <p>See Appendix A for focus area contact information.</p>

Infants weighing 1,000 grams or less at birth in intensive care

14-20d. Central line-associated bloodstream infection.

National Data Source	National Nosocomial Infections Surveillance (NNIS) System, CDC, NCID.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.5 (Immunization and Infectious Diseases).
Measure	Rate per 1,000 days' use.
Baseline	12.2 (1998).
Numerator	Number of hospital-acquired central line-associated bloodstream infections among infants with a birth weight of 1,000 grams or less.
Denominator	Number of central line-days among infants with a birth weight of 1,000 grams or less.
Population Targeted	Acute care general hospital patient population.
Questions Used To Obtain the National Data	<p>Numerator: CDC National Nosocomial Infections Surveillance System Infection Worksheet, Form 57.58D, Rev. 01/98.</p> <p>Denominator: CDC National Nosocomial Infections Surveillance System High Risk Nursery (HRN) Surveillance Monthly Report Form, Form 57.58H, Rev. 01/98.</p>
Expected Periodicity	Annual.
Comments	<p>The 1998 point estimate represents an aggregate of data from high-risk nurseries (level II-III neonatal intensive care units) from January 1990 through May 1999.</p> <p>Data may not be representative of all U.S. hospitals. For each year of data collection, not all participating hospitals are represented.</p> <p>Detailed surveillance protocols used in NNIS System, including all data field definitions, can be found in the <i>NNIS Manual</i>, May 1999 (available by request to NNIS hospitals, State health departments, and international ministries of health).¹² Definitions of infections and key data fields and a description of the protocols are available.^{13, 14}</p>

This objective is a modification of Healthy People 2000 objective 20.5, which tracked bloodstream infection rates per 1,000 device days among patients by specific type of intensive care unit categories (surgical ICUs, medical ICUs, and pediatric ICUs). This measure tracks central line-associated bloodstream infection rates per 1,000 days' use among infants weighing 1,000 grams or less at birth in all level II-III neonatal ICUs.

See Appendix A for focus area contact information.



14-20e. Ventilator-associated pneumonia.

National Data Source	National Nosocomial Infections Surveillance (NNIS) System, CDC, NCID.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.5 (Immunization and Infectious Diseases)
Measure	Rate per 1,000 days' use.
Baseline	4.9 (1998).
Numerator	Number of hospital-acquired ventilator-associated pneumonia infections among infants with a birth weight of 1,000 grams or less.
Denominator	Number of ventilator-days among infants with a birth weight of 1,000 grams or less.
Population Targeted	Acute care general hospital patient population.
Questions Used To Obtain the National Data	<p>Numerator: CDC National Nosocomial Infections Surveillance System Infection Worksheet, Form 57.58D, Rev. 01/98.</p> <p>Denominator: CDC National Nosocomial Infections Surveillance System High Risk Nursery (HRN) Surveillance Monthly Report Form, Form 57.58H, Rev. 01/98, and CDC National Nosocomial Infections Surveillance System High Risk Nursery (HRN) Surveillance Monthly Report Form, Form 57.58H, Rev. 01/98.</p>
Expected Periodicity	Annual.

Comments

The 1998 point estimate represents an aggregate of data from high-risk nurseries (level II-III neonatal intensive care units) from January 1990 through May 1999.

Data may not be representative of all U.S. hospitals. For each year of data collection, not all participating hospitals are represented.

Detailed surveillance protocols used in NNIS System, including all data field definitions, can be found in the *NNIS Manual*, May 1999 (available by request to NNIS hospitals, State health departments, and international ministries of health).¹² Definitions of infections and key data fields and a description of the protocols are available.^{13, 14}

This objective is a modification of Healthy People 2000 objective 20.5, which tracked pneumonia infection rates per 1,000 device days among patients in pediatric ICUs. This measure tracks ventilator-associated pneumonia infection rates per 1,000 days' use among infants weighing 1,000 grams or less at birth in all level II-III neonatal ICUs.

See Appendix A for focus area contact information.



14-21. Reduce antimicrobial use among intensive care unit patients.

National Data Source	National Nosocomial Infections Surveillance (NNIS) System, CDC, NCID.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.5 (Immunization and Infectious Diseases).
Measure	Rate per 1,000 Intensive Care Unit (ICU) days.
Baseline	150 (1995).
Numerator	Number of defined daily doses of FDA-approved antimicrobial agents or grams per day of FDA-approved antimicrobial agents of all patients hospitalized in the intensive care unit.
Denominator	Number of all the days of all the patients that are hospitalized in the ICU (number of patient-days).

Population Targeted	Acute care general hospital patient population.
Questions Used To Obtain the National Data	CDC National Nosocomial Infections Surveillance System Antimicrobial Use and Resistance Component Monthly Report Form.
Expected Periodicity	Annual.
Comments	<p>The 1995 point estimate represents an aggregate of data for 1994–95.</p> <p>Grams of specific antibiotics used in intensive care units are based on reports by participating NNIS hospitals. Defined daily dose estimates are available for most FDA-approved antimicrobial agents.</p> <p>Data may not be representative of all U.S. hospitals. Not all antimicrobial agents are included in the surveillance system. For each year of data collection, not all participating hospitals are necessarily represented. The appropriateness of antibiotic therapies is not addressed in this measure.</p> <p>Agents dosed by patient weight (i.e., aminoglycosides, macrolides) are defined by total grams administered daily.</p> <p>See Appendix A for focus area contact information.</p>



Vaccination Coverage and Strategies

14-22. Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children.

4-22a. 4 doses of diphtheria-tetanus-acellular pertussis (DTaP) vaccine.

National Data Source	National Immunization Survey (NIS), CDC, NIP and NCHS.
State Data Source	National Immunization Survey (NIS), CDC, NIP and NCHS.
Healthy People 2000 Objective	Adapted from 20.11 (Immunization and Infectious Diseases).
Measure	Percent.

Baseline	84 (1998).
Numerator	Number of children aged 19 to 35 months receiving at least four or more doses of the combination of diphtheria, tetanus, and acellular pertussis antigens.
Denominator	Children aged 19 to 35 months.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Immunization Survey Household Survey:</p> <ul style="list-style-type: none"> ➤ <i>How many D-T-P or D-T shots (sometimes called a D-P-T shot, diphtheria-tetanus-pertussis shot, baby shot, three-in-one shot) has (<u>Sample child</u>) ever received?</i> ➤ <i>Other shots received?</i> <p>From the 1998 National Immunization Survey Provider Record Check:</p> <ul style="list-style-type: none"> ➤ <i>Specify month, day and year that each immunization was given, either by the office or another provider (OP), as documented in the records.</i>
Expected Periodicity	Annual.
Comments	<p>The National Immunization Survey (NIS) is a continuing nationwide telephone sample survey among children aged 19 to 35 months. Estimates of vaccine-specific coverage are available for the United States, each State, and 28 urban areas considered to be high risk for under-vaccination. NIS uses a two-phase sample design. First, a random-digit-dialing (RDD) sample of telephone numbers is drawn. In 1995, 69 percent of households with age-eligible children completed vaccination interviews, yielding data for 31,997 children.</p>

The interviewer also asks for permission to contact the vaccination provider. In the second phase, all vaccination providers are contacted by mail. Vaccination information from providers' records was obtained for 52 percent of all children who were eligible for provider followup in 1995 and 64 percent in 1996. Providers' responses are combined with information obtained from households to provide a more accurate estimate of vaccination coverage levels. Final estimates are adjusted for noncoverage of nontelephone households.

For further information, visit the National Immunization Survey Web site at <http://www.nisabt.org/>.

Statistical adjustments are made to minimize bias due to (1) lower coverage among children living in households without telephones, (2) discrepancies between vaccinations reported by household compared with immunization providers, and (3) differences in race/ethnic population distribution in sample compared to race/ethnic population distribution at birth.

This measure is a modification of its comparable Healthy People 2000 objective 20.11, which tracked the number of children aged 19 to 35 months receiving three or more doses of the combination of diphtheria, tetanus, and pertussis antigens (DTP).

This baseline measure tracks the number of children aged 19 to 35 months receiving four or more doses of the combination of diphtheria, tetanus, and acellular pertussis antigens (DTaP) as well as those children who received the combination of diphtheria, tetanus, and pertussis antigens (DTP).

See Appendix A for focus area contact information.



14-22b. 3 doses Haemophilus influenzae type b (Hib) vaccine.

National Data Source	National Immunization Survey (NIS), CDC, NIP and NCHS.
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State Data Source	National Immunization Survey (NIS), CDC, NIP and NCHS.
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Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases).
Measure	Percent.
Baseline	93 (1998).
Numerator	Number of children aged 19 to 35 months receiving at least three doses of the <i>Haemophilus influenzae</i> B antigen.
Denominator	Children aged 19 to 35 months.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Immunization Survey Household Survey:</p> <ul style="list-style-type: none"> ➤ <i>How many H-I-B shots (this is for Meningitis and is called Haemophilus Influenzae), H-I-B vaccine, or H flu vaccine has (<u>Sample child</u>) ever received?</i> ➤ <i>Other shots received?</i> <p>From the 1998 National Immunization Survey Provider Record Check:</p> <ul style="list-style-type: none"> ➤ <i>Specify month, day and year that each immunization was given, either by the office or another provider (OP), as documented in the records.</i>
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-22a for more information.



14-22c. 3 doses hepatitis B (hep B) vaccine.

National Data Source	National Immunization Survey (NIS), CDC, NIP and NCHS.
State Data Source	National Immunization Survey (NIS), CDC, NIP and NCHS.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases)
Measure	Percent.
Baseline	87 (1998).

Numerator	Number of children aged 19 to 35 months receiving at least three doses of the hepatitis B antigen.
Denominator	Children aged 19 to 35 months.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Immunization Survey Household Survey:</p> <ul style="list-style-type: none"> ➤ <i>How many Hepatitis B shots has (<u>Sample child</u>) ever received?</i> ➤ <i>Other shots received?</i> <p>From the 1998 National Immunization Survey Provider Record Check:</p> <ul style="list-style-type: none"> ➤ <i>Specify month, day and year that each immunization was given, either by the office or another provider (OP), as documented in the records.</i>
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-22a for more information.



14-22d. 1 dose measles-mumps-rubella (MMR) vaccine.

National Data Source	National Immunization Survey (NIS), CDC, NIP and NCHS.
State Data Source	National Immunization Survey (NIS), CDC, NIP and NCHS.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases).
Measure	Percent.
Baseline	92 (1998).
Numerator	Number of children aged 19 to 35 months receiving at least one dose of the combination of measles, mumps, and rubella antigens.
Denominator	Children aged 19 to 35 months.
Population Targeted	U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data

From the 1998 National Immunization Survey Household Survey:

- *How many measles or M-M-R (Measles-Mumps-Rubella) shots has (Sample child) ever received?*
- *Other shots received?*

From the 1998 National Immunization Survey Provider Record Check:

- *Specify month, day and year that each immunization was given, either by the office or another provider (OP), as documented in the records.*

Expected Periodicity

Annual.

Comments

The MMR estimate for 1998 is based on all measles-containing vaccines.

See Comments provided with objective 14-22a for more information.



14-22e. 3 doses polio vaccine.

National Data Source

National Immunization Survey (NIS), CDC, NIP and NCHS.

State Data Source

National Immunization Survey (NIS), CDC, NIP and NCHS.

Healthy People 2000 Objective

20.11 (Immunization and Infectious Diseases).

Measure

Percent.

Baseline

91 (1998).

Numerator

Number of children aged 19 to 35 months receiving at least three doses of the polio antigen.

Denominator

Children aged 19 to 35 months.

Population Targeted

U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data

From the 1998 National Immunization Survey Household Survey:

- *How many polio vaccine shots (by mouth, pink drops, or by a polio shot) has (Sample child) ever received?*
- *Other shots received?*

From the 1998 National Immunization Survey
Provider Record Check:

- *Specify month, day and year that each immunization was given, either by the office or another provider (OP), as documented in the records.*

Expected Periodicity Annual.

Comments See Comments provided with objective 14-22a for more information.



14-22f. 1 dose varicella vaccine.

National Data Source National Immunization Survey (NIS), CDC, NIP and NCHS.

State Data Source National Immunization Survey (NIS), CDC, NIP and NCHS.

Healthy People 2000 Objective Not applicable.

Measure Percent.

Baseline 43 (1998).

Numerator Number of children aged 19 to 35 months receiving at least one dose of the varicella antigen.

Denominator Children aged 19 to 35 months.

Population Targeted U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data From the 1998 National Immunization Survey Household Survey:

- *How many chicken pox (or Varicella) shots has (Sample child) ever received?*
- *Other shots received?*

From the 1998 National Immunization Survey
Provider Record Check:

- *Specify month, day and year that each immunization was given, either by the office or another provider (OP), as documented in the records.*

Expected Periodicity Annual.

Comments See Comments provided with objective 14-22a for more information.

14-23. Maintain vaccination coverage levels for children in licensed day care facilities and children in kindergarten through the first grade.

Children in day care

14-23a. Diphtheria-tetanus-acellular pertussis (DTaP) vaccine.

National Data Source	Annual Immunization Assessment Reports, CDC, NIP.
State Data Source	Annual Immunization Assessment Reports, CDC, NIP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases).
Measure	Percent (2-year average).
Baseline	96 (1997–98).
Numerator	Number of surveyed enrollees in day care centers who received the combination of diphtheria, tetanus, and either acellular pertussis or pertussis antigens.
Denominator	Number of surveyed enrollees in day care centers.
Population Targeted	U.S. day care center population.
Questions Used To Obtain the National Data	CDC Annual Immunization Assessment Report: Day Care Centers, Head Start Centers, and Schools.
Expected Periodicity	Biennial.
Comments	<p>Baseline includes enrollees who received the combination of diphtheria, tetanus, and pertussis antigens.</p> <p>States may collect and/or report data on selective antigens depending upon school entry requirements.</p> <p>Overall (national) mean coverage levels are estimated by weighting the vaccine-specific coverage levels reported by States and territories to their respective birth cohorts.</p> <p>Sampling methodology may vary by State.</p> <p>See Appendix A for focus area contact information.</p>



14-23b. Measles/mumps/rubella vaccines.

National Data Source	Annual Immunization Assessment Reports, CDC, NIP.
State Data Source	Annual Immunization Assessment Reports, CDC, NIP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases).
Measure	Percent (2-year average).
Baseline	89 (1997–98).
Numerator	Number of surveyed enrollees in day care centers who received the combination of measles, mumps, and rubella antigens.
Denominator	Number of surveyed enrollees in day care centers.
Population Targeted	U.S. day care center population.
Questions Used To Obtain the National Data	CDC Annual Immunization Assessment Report: Day Care Centers, Head Start Centers, and Schools.
Expected Periodicity	Biennial.
Comments	See Comments provided with objective 14-23a for more information.

**14-23c. Polio vaccine.**

National Data Source	Annual Immunization Assessment Reports, CDC, NIP.
State Data Source	Annual Immunization Assessment Reports, CDC, NIP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases)
Measure	Percent (2-year average).
Baseline	96 (1997–98).
Numerator	Number of surveyed enrollees in day care centers who received the polio antigen.
Denominator	Number of surveyed enrollees in day care centers.
Population Targeted	U.S. day care center population.

Questions Used To Obtain the National Data	CDC Annual Immunization Assessment Report: Day Care Centers, Head Start Centers, and Schools.
Expected Periodicity	Biennial.
Comments	See Comments provided with objective 14-23a for more information.



14-23d. (Developmental) Hepatitis B vaccine.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>The proposed national and State data sources are the Annual Immunization Assessment Reports, CDC, NIP.</p> <p>The proposed numerator is the number of surveyed enrollees in day care centers who received the hepatitis B antigen. The proposed denominator is the number of surveyed enrollees in day care centers.</p> <p>See Appendix A for focus area contact information.</p>
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14-23e. (Developmental) Varicella vaccine.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>The proposed national and State data sources are the Annual Immunization Assessment Reports, CDC, NIP.</p> <p>The proposed numerator is the number of surveyed enrollees in day care centers who received the varicella antigen. The proposed denominator is the number of surveyed enrollees in day care centers.</p> <p>See Appendix A for focus area contact information.</p>
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Children in K through 1st grade

14-23f. Diphtheria-tetanus-acellular pertussis (DTaP) vaccine.

National Data Source	Annual Immunization Assessment Reports, CDC, NIP.
State Data Source	Annual Immunization Assessment Reports, CDC, NIP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases).
Measure	Percent (2-year average).
Baseline	97 (1997–98).
Numerator	Number of surveyed enrollees in kindergarten and/or first grade who received the combination of diphtheria, tetanus, and either acellular pertussis or pertussis antigens.
Denominator	Number of surveyed enrollees in kindergarten and/or first grade.
Population Targeted	U.S. kindergarten and first grade student population.
Questions Used To Obtain the National Data	CDC Annual Immunization Assessment Report: Day Care Centers, Head Start Centers, and Schools.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-23a for more information.



14-23g. Measles/mumps/rubella vaccines.

National Data Source	Annual Immunization Assessment Reports, CDC, NIP.
State Data Source	Annual Immunization Assessment Reports, CDC, NIP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases).
Measure	Percent (2-year average).
Baseline	96 (1997–98).

Numerator	Number of surveyed enrollees in kindergarten and/or first grade who received the combination of measles, mumps, and rubella antigens.
Denominator	Number of surveyed enrollees in kindergarten and/or first grade.
Population Targeted	U.S. kindergarten and first grade student population.
Questions Used To Obtain the National Data	CDC Annual Immunization Assessment Report: Day Care Centers, Head Start Centers, and Schools.
Expected Periodicity	Annual.
Comments	See Comments with objective 14-23a for more information.



14-23h. Polio vaccine.

National Data Source	Annual Immunization Assessment Reports, CDC, NIP.
State Data Source	Annual Immunization Assessment Reports, CDC, NIP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases)
Measure	Percent (2-year average).
Baseline	97 (1997–98).
Numerator	Number of surveyed enrollees in kindergarten and/or first grade who received the polio antigen.
Denominator	Number of surveyed enrollees in kindergarten and/or first grade.
Population Targeted	U.S. kindergarten and first grade student population.
Questions Used To Obtain the National Data	CDC Annual Immunization Assessment Report: Day Care Centers, Head Start Centers, and Schools.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-23a for more information.



14-23i. (Developmental) Hepatitis B vaccine.

Comments

An operational definition could not be specified at the time of publication.

The proposed national and State data sources are the Annual Immunization Assessment Reports, CDC, NIP.

The proposed numerator is the number of surveyed enrollees in kindergarten and/or first grade who received the hepatitis B antigen. The proposed denominator is the number of surveyed enrollees in kindergarten and/or first grade.

See Appendix A for focus area contact information.



14-23j. (Developmental) Varicella vaccine.

Comments

An operational definition could not be specified at the time of publication.

The proposed national and State data sources are the Annual Immunization Assessment Reports, CDC, NIP.

The proposed numerator is the number of surveyed enrollees in kindergarten and/or first grade who received the varicella antigen. The proposed denominator is the number of surveyed enrollees in kindergarten and/or first grade.

See Appendix A for focus area contact information.



14-24. Increase the proportion of young children and adolescents who receive all vaccines that have been recommended for universal administration for at least 5 years.

14-24a. Children aged 19 to 35 months who received the recommended vaccines (4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B).

National Data Source

National Immunization Survey (NIS), CDC, NIP and NCHS.

State Data Source	National Immunization Survey (NIS), CDC, NIP and NCHS.
Healthy People 2000 Objective	Adapted from 20.11 (Immunization and Infectious Diseases).
Leading Health Indicator	Immunization.
Measure	Percent.
Baseline	73 (1998).
Numerator	Number of children aged 19 to 35 months receiving at least four doses of diphtheria-tetanus-acellular pertussis (DTaP), at least three doses of polio, at least one dose of measles-mumps-rubella (MMR), at least three doses of <i>Haemophilus influenzae</i> B (Hib), and at least three doses of hepatitis B antigens.
Denominator	Children aged 19 to 35 months.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Immunization Survey Household Survey:</p> <ul style="list-style-type: none"> ➤ <i>How many D-T-P or D-T shots (sometimes called a D-P-T shot, diphtheria-tetanus-pertussis shot, baby shot, three-in-one shot) has (<u>Sample child</u>) ever received?</i> ➤ <i>How many polio vaccine shots (by mouth, pink drops, or by a polio shot) has (<u>Sample child</u>) ever received?</i> ➤ <i>How many measles or M-M-R (Measles-Mumps-Rubella) shots has (<u>Sample child</u>) ever received?</i> ➤ <i>How many H-I-B shots (this is for Meningitis and is called Haemophilus Influenzae), H-I-B vaccine, or H flu vaccine has (<u>Sample child</u>) ever received?</i> ➤ <i>How many Hepatitis B shots has (<u>Sample child</u>) ever received?</i> ➤ <i>Other shots received?</i> <p>From the 1998 National Immunization Survey Provider Record Check:</p> <ul style="list-style-type: none"> ➤ <i>Specify month, day and year that each immunization was given, either by the office or another provider (OP), as documented in the records.</i>
Expected Periodicity	Annual.

Comments

Any new vaccines that have been universally recommended for at least 5 years will be added to the series over the course of Healthy People 2010.

See Comments provided with objective 14-22a for more information on NIS.

This objective differs from the comparable measure in Healthy People 2000 objective 20.11, which tracked children aged 19 to 35 months with at least four doses of diphtheria-tetanus-pertussis (DTAP), at least three doses of polio, and at least one dose of measles-mumps-rubella (MMR) only. This objective adds *Haemophilus influenzae* type B and hepatitis B.

This objective is one of the measures used to track the Immunization Leading Health Indicator. See Appendix H for a complete listing.

See Appendix A for focus area contact information.



14-24b. (Developmental) Adolescents aged 13 to 15 years who received the recommended vaccines.

Comments

An operational definition could not be provided at the time of publication.

The proposed source is the National Health Interview Survey (NHIS), CDC, NCHS.

Currently there are no vaccines for adolescents aged 13 to 15 years that have been universally recommended for at least 5 years. As vaccines for adolescents aged 13 to 15 years are identified over the course of Healthy People 2010, they will be tracked.

See Part C for a description of NHIS and Appendix A for focus area contact information.



14-25. Increase the proportion of providers who have measured the vaccination coverage levels among children in their practice population within the past 2 years.

14-25a. Public health providers.

National Data Source	Immunization Program Annual Reports, CDC, NIP.
State Data Source	Immunization Program Annual Reports, CDC, NIP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	66 (1997).
Numerator	Number of public provider sites that routinely provided immunizations in the past 2 years to children under age 6 years and participated in a provider assessment at least once in the past 2 years.
Denominator	Number of public provider sites that routinely provided immunizations in the past 2 years to children under age 6 years.
Questions Used To Obtain the National Data	<p>From the 1997 Immunization Program Annual Report:</p> <ul style="list-style-type: none"> ➤ <i>Enter the number of public provider sites, by type, that routinely provide immunizations to children aged less than 6 years:</i> <ul style="list-style-type: none"> _____ <i>Health department clinics</i> _____ <i>Community/migrant health centers</i> _____ <i>Indian Health Service/Tribal clinics</i> _____ <i>Other public providers</i> ➤ <i>How many private provider sites in your jurisdiction provide immunizations to preschool children?</i> ➤ <i>Status of Assessment and Feedback of Provider Immunization Practices:</i> <ul style="list-style-type: none"> _____ <i>Number of public provider sites (by type of public provider) that participated in a clinic assessment</i> _____ <i>Number of private provider sites (by type of private provider) that participated in a provider assessment</i>
Expected Periodicity	Annual.

Comments

A provider site is a service delivery location that maintains permanent records, excluding temporary locations or mobile immunization clinics or fairs and the like. Well-child clinics and immunization-only clinics in the same location should be counted as separate sites only if they maintain separate sets of records.

Public providers include health department clinics, community/migrant health centers, Indian Health Service/Tribal health clinics, or other public providers (for example, any other public clinic that provides immunizations, such as a county medical center outpatient clinic).

Private providers are individual or group primary care or pediatric practices and may include providers for which some or all of their clients are members of different managed care plans or managed care organizations.

A public provider assessment is an assessment that includes a review of a random sample (or 100 percent) of immunization records of 2-year-olds. The assessment may have been conducted by project, clinic, or contractual personnel.

A private provider assessment is an assessment that includes a review of a random sample (or 100 percent) of immunization records of 2-year-olds. The assessment may have been conducted either by immunization project staff or through a contractual agreement that provides this service.

See Appendix A for focus area contact information.



14-25b. Private providers.

National Data Source	Immunization Program Annual Reports, CDC, NIP.
State Data Source	Immunization Program Annual Reports, CDC, NIP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	6 (1997).

Numerator	Number of private provider sites that routinely provided immunizations in the past 2 years to children under age 6 years and participated in a provider assessment at least once in the past 2 years.
Denominator	Number of private provider sites that routinely provided immunizations in the past 2 years to children under age 6 years.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 14-25a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-25a for more information.



14-26. Increase the proportion of children who participate in fully operational population-based immunization registries.

National Data Source	Immunization Program Annual Reports, CDC, NIP.
State Data Sources	State Immunization Program Survey, CDC, NIP; Community Population-Based Registry Reports.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	32 (1999).
Numerator	Number of children under age 6 years who have at least one immunization record in the registry.
Denominator	Number of children under age 6 years.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	From the 1998 State Immunization Program Survey: ➤ <i>How many children less than 6 years old (0-5 year olds) are in your catchment area?</i>

- *How many children less than 6 years old (0-5 year olds) are in your registry and have at least one vaccination recorded (excluding the first hepatitis B dose at birth)?*

Expected Periodicity Annual.

Comments Baseline is a proxy measure. By 2005, data from the registry systems will be used to track this objective, instead of the current survey data from immunization program grantees.

Starting in 2000, questions will be asked about children under age 6 years who are in the registry and have two vaccinations recorded.

See Appendix A for focus area contact information.



14-27. Increase routine vaccination coverage levels for adolescents.

14-27a. 3 or more doses of hepatitis B.

National Data Source	National Health Interview Survey (NHIS), CDC, NHIS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.11 (Immunization and Infectious Diseases).
Measure	Percent.
Baseline	48 (1997).
Numerator	Number of adolescents aged 13 to 15 years reported to be vaccinated with three or more doses of the hepatitis B antigens.
Denominator	Number of adolescents aged 13 to 15 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997 National Health Interview Survey: <ul style="list-style-type: none"> ➤ <i>Are shot records available for (<u>Child's name</u>)?</i> ➤ <i>Are all the immunizations the (<u>Child's name</u>) ever received included in this shot record?</i>

- *Are there any OTHER immunizations listed on the shot record that I have NOT asked you about?*

[If yes:]

- *What are the names of OTHER immunizations listed on the shot record that I have NOT asked you about?*

Influenza

Pneumococcal

Hepatitis A

Other immunizations

- *Has (Child's name) ever received an additional Hepatitis B shot?*

[If yes:]

- *How many additional Hepatitis B shots has (Child's name) ever received?*

[If no shot record (or incomplete):]

- *Has (Child's name) ever received an immunization (that is a shot or drops)?*

Expected Periodicity Annual.

Comments This objective is a modification of Healthy People 2000 objective 20.11, which tracked immunization coverage for selected antigens (three or more doses of DTP, three or more doses of polio, one or more doses of measles-containing, three or more doses of Haemophilus influenzae type B, and three or more doses of hepatitis B) among children aged 19 to 35 months. This objective tracks selected antigens (two or more doses of MMR, three or more doses of hepatitis B, one or more doses of varicella if indicated, and one or more doses of tetanus-diphtheria booster) among adolescents aged 13 to 15 years.

See Part C for a description of NHIS and Appendix A for focus area contact information.



14-27b. 2 or more doses of measles, mumps, rubella.

National Data Source National Health Interview Survey (NHIS), CDC, NHIS.

State Data Source Not identified.

Healthy People 2000 Objective	Adapted from 20.11 (Immunization and Infectious Diseases).
Measure	Percent.
Baseline	89 (1997).
Numerator	Number of adolescents aged 13 to 15 years reported to be vaccinated with two or more doses of the measles, mumps, and rubella antigens.
Denominator	Number of adolescents aged 13 to 15 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Health Interview Survey:</p> <ul style="list-style-type: none"> ➤ <i>Are shot records available for (<u>Child's name</u>)?</i> ➤ <i>Are all the immunizations the (<u>Child's name</u>) ever received included in this shot record?</i> ➤ <i>Are there any OTHER immunizations listed on the shot record that I have NOT asked you about?</i> <ul style="list-style-type: none"> [If yes:] <ul style="list-style-type: none"> ○ <i>What are the names of OTHER immunizations listed on the shot record that I have NOT asked you about?</i> <ul style="list-style-type: none"> <i>Influenza</i> <i>Pneumococcal</i> <i>Hepatitis A</i> <i>Other immunizations</i> ➤ <i>Has (<u>Child's name</u>) ever received an additional measles or MMR (measles, mumps, rubella) shot?</i> <ul style="list-style-type: none"> [If yes:] <ul style="list-style-type: none"> ○ <i>How many additional measles or MMR (measles, mumps, rubella) shots has (<u>Child's name</u>) ever received?</i> [If no shot record (or incomplete):] <ul style="list-style-type: none"> ○ <i>Has (<u>Child's name</u>) ever received an immunization (that is a shot or drops)?</i>
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-27a for more information.



14-27c. 1 or more doses of tetanus-diphtheria booster.

National Data Source	National Health Interview Survey (NHIS), CDC, NHIS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.11 (Immunization and Infectious Diseases).
Measure	Percent.
Baseline	93 (1997).
Numerator	Number of adolescents aged 13 to 15 years reported to be vaccinated with two or more doses of the tetanus and diphtheria antigens.
Denominator	Number of adolescents aged 13 to 15 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Health Interview Survey:</p> <ul style="list-style-type: none">➤ <i>Are shot records available for (Child's name)?</i>➤ <i>Are all the immunizations the (Child's name) ever received included in this shot record?</i>➤ <i>Are there any OTHER immunizations listed on the shot record that I have NOT asked you about?</i><ul style="list-style-type: none">[If yes:]<ul style="list-style-type: none">○ <i>What are the names of OTHER immunizations listed on the shot record that I have NOT asked you about?</i><ul style="list-style-type: none"><i>Influenza</i><i>Pneumococcal</i><i>Hepatitis A</i><i>Other immunizations</i>➤ <i>Has (Child's name) ever received an additional tetanus-diphtheria (Td) shot?</i><ul style="list-style-type: none">[If yes:]<ul style="list-style-type: none">○ <i>How many additional tetanus-diphtheria (Td) shots has {Child's name} ever received?</i>[If no shot record (or incomplete):]<ul style="list-style-type: none">○ <i>Has (Child's name) ever received an immunization (that is a shot or drops)?</i>
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-27a for more information.

14-27d. 1 or more doses of varicella.

National Data Source	National Health Interview Survey (NHIS), CDC, NHIS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 20.11 (Immunization and Infectious Diseases).
Measure	Percent.
Baseline	45 (1997).
Numerator	Number of adolescents aged 13 to 15 years reported to be vaccinated with two or more doses of the varicella antigen, excluding those who are reported to ever have had varicella (chicken pox).
Denominator	Number of adolescents aged 13 to 15 years excluding those who are reported to ever have had varicella (chicken pox).
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997 National Health Interview Survey:

[NUMERATOR:]

- *Are shot records available for (Child's name)?*
- *Are all the immunizations the (Child's name) ever received included in this shot record?*
- *Are there any OTHER immunizations listed on the shot record that I have NOT asked you about?*

[If yes:]

- *What are the names of OTHER immunizations listed on the shot record that I have NOT asked you about?*

Influenza

Pneumococcal

Hepatitis A

Other immunizations

- *Has (Child's name) ever received an additional chicken pox shot?*

[If yes:]

- *How many additional chicken pox shots has (Child's name) ever received?*

[If no shot record (or incomplete):]

- *Has (Child's name) ever received an immunization (that is a shot or drops)?*

[DENOMINATOR:]

- *Has (Child's name) EVER had chicken pox?*

Expected Periodicity Annual.

Comments See Comments provided with objective 14-27a for more information.



14-28. Increase hepatitis B vaccine coverage among high-risk groups.

14-28a. Long-term hemodialysis patients.

National Data Source	Annual Survey of Chronic Hemodialysis Centers, CDC, NCID and HCFA.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	35 (1995).
Numerator	Number of patients receiving chronic hemodialysis who have ever received at least three doses of hepatitis B vaccine.
Denominator	Number of patients receiving chronic hemodialysis.
Population Targeted	U.S. chronic hemodialysis patient population.
Questions Used To Obtain the National Data	From the 1995 Annual Survey of Chronic Hemodialysis Centers: <ul style="list-style-type: none">➤ <i>How many patients were assigned to your hemodialysis center as of (date of survey)?</i>➤ <i>How many of these patients had ever in their lives received at least 3 doses of hepatitis B vaccine?</i>
Expected Periodicity	Annual.
Comments	See Appendix A for focus area contact information.

14-28b. Men who have sex with men.

Comments	<p>A complete operational definition was not provided at the time of publication.</p> <p>The national data source is the Young Men's Survey, National Center for HIV, STD, and TB Prevention, CDC, NCHSTP.</p> <p>This objective is comparable to one of the measures in Healthy People 2000 objective 20.11 (Immunization and Infectious Diseases).</p> <p>See Appendix A for focus area contact information.</p>
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14-28c. Occupationally exposed workers.

National Data Source	Periodic Vaccine Coverage Surveys, CDC, NCID (See Comments).
State Data Source	Not identified.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases) (also 10.9).
Measure	Percent.
Baseline	71 (1995).
Numerator	Number of health care workers reported by participating facilities to have received at least three doses of hepatitis B vaccine.
Denominator	Number of health care workers employed at participating facilities.
Population Targeted	U.S. health care worker population.
Questions Used To Obtain the National Data	<p>From the 1995 survey:^{15, 16}</p> <ul style="list-style-type: none">➤ <i>How many full-time and part-time staff who had direct contact with patients were employed at your center?</i>➤ <i>How many of these staff had ever received at least 3 doses of hepatitis B vaccine?</i>
Expected Periodicity	Periodic.

Comments

Methodology on measuring this objective has been previously published.^{15, 16}

The expected periodicity for measuring this objective is every 5 years.

See Appendix A for focus area contact information.

**14-29. Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.****Noninstitutionalized adults aged 65 years and older****14-29a. Influenza vaccine.**

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases), age adjusted to the 2000 standard population.
Leading Health Indicator	Immunization.
Measure	Percent (age adjusted—see Comments).
Baseline	64 (1998).
Numerator	Number of adults aged 65 years and older who report receiving an influenza vaccination in the past 12 months.
Denominator	Number of adults aged 65 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey: ➤ <i>During the PAST 12 MONTHS, have you had a flu shot? A flu shot is usually given in the fall and protects against influenza for the flu season.</i>
Expected Periodicity	Annual.

Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p> <p>This objective is one of the measures used to track the Immunization Leading Health Indicator. See Appendix H for a complete listing.</p> <p>See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.</p>
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14-29b. Pneumococcal vaccine.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases), age adjusted to the 2000 standard population.
Leading Health Indicator	Immunization.
Measure	Percent (age adjusted—see Comments).
Baseline	46 (1998).
Numerator	Number of adults aged 65 years and older who report ever receiving a pneumococcal vaccination.
Denominator	Number of adults aged 65 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>➤ <i>Have you EVER had a pneumonia vaccination? This shot is usually given only once in a person's lifetime and is different from the flu shot.</i></p>
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-29a for more information.

Noninstitutionalized high-risk adults aged 18 to 64 years

14-29c. Influenza vaccine.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	26 (1998).
Numerator	Number of high-risk persons aged 18 to 64 years who report receiving an influenza vaccination in the past 12 months.
Denominator	Number of high-risk persons aged 18 to 64 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey:

[NUMERATOR:]

- *During the PAST 12 MONTHS, have you had a flu shot? A flu shot is usually given in the fall and protects against influenza for the flu season.*

[DENOMINATOR:]

- *Have you EVER been told by a doctor or other health professional that you had...*
 - ... Hypertension, also called high blood pressure?*
 - ... Coronary heart disease?*
 - ... Angina, also called angina pectoris?*
 - ... A heart attack (also called myocardial infarction)?*
 - ... Any kind of heart condition or heart disease (other than the ones I just asked about)?*
 - ... A stroke*
 - ... Emphysema?*
 - ... Asthma?*
- *During the PAST 12 MONTHS, have you had an episode of asthma or asthma attack?*
- *Have you EVER been told by a doctor or other health professional that you had ...*
 - ... Cancer or a malignancy of any kind?*

[If yes:]

○ *What kind of cancer was it?*

- (1) *Bladder*
- (2) *Blood*
- (3) *Bone*
- (4) *Brain*
- (5) *Breast*
- (6) *Cervix*
- (7) *Colon*
- (8) *Esophagus*
- (9) *Gallbladder*
- (10) *Kidney*
- (11) *Larynx - windpipe*
- (12) *Leukemia*
- (13) *Liver*
- (14) *Lung*
- (15) *Lymphoma*
- (16) *Melanoma*
- (17) *Mouth/tongue/lip*
- (18) *Ovary*
- (19) *Pancreas*
- (20) *Prostate*
- (21) *Rectum*
- (22) *Skin (non-melanoma)*
- (23) *Skin (DK what kind)*
- (24) *Soft Tissue (muscle or fat)*
- (25) *Stomach*
- (26) *Testes*
- (27) *Throat - pharynx*
- (28) *Thyroid*
- (29) *Uterus*
- (30) *Other*
- (96) *More than 3 kinds*

➤ *(Other than during pregnancy,) Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?*

➤ *During the PAST 12 MONTHS, have you been told by a doctor or other health professional that you had..*

... *Chronic bronchitis?*

... *Weak or failing kidneys? - Do not include kidney stones, bladder infections or incontinence.*

... *Any kind of liver condition?*

➤ *Are you currently pregnant?*

Expected Periodicity Annual.

Comments

A high-risk person is defined as a respondent who answered “yes” to one or more of the conditions listed in the questions above. The only condition not included in the definition of high risk is skin cancer (see conditions 22 and 23 listed in Questions Used To Obtain the National Data above). High-risk adults are defined by the Advisory Committee on Immunization Practices (ACIP).

Not all high-risk conditions for complications of influenza and pneumococcal disease can be ascertained by NHIS (for example, immunocompromised), and the sample size may be too small for some groups.

This objective is a modification of Healthy People 2000 objective 20.11, which tracked influenza vaccinations in the past 12 months among persons aged 65 years and older. This measure tracks high-risk persons aged 18 to 64 years.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and BRFSS, and Appendix A for focus area contact information.



14-29d. Pneumococcal vaccine.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	13 (1998).
Numerator	Number of high-risk persons aged 18 to 64 years who report ever receiving a pneumococcal vaccination.
Denominator	Number of high-risk persons aged 18 to 64 years.

Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data for objectives 14-29b (numerator only) and 14-29c (denominator only).
Expected Periodicity	Annual.
Comments	See Comments provided with objective 14-29c for more information.



Institutionalized adults (persons in long-term care or nursing homes)

14-29e. Influenza vaccine.

National Data Source	National Nursing Home Survey (NNHS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	59 (1997).
Numerator	Number of persons in long-term care facilities and nursing homes reported to have received an influenza vaccination in the past 12 months.
Denominator	Number of persons in long-term care facilities and nursing homes.
Population Targeted	U.S. resident population (see Comments).
Questions Used To Obtain the National Data	From the 1997 National Nursing Home Survey: ➤ <i>During the past 12 months, has (<u>Name</u>) had a flu shot at this facility or any other location?</i>
Expected Periodicity	Biennial.
Comments	Data are from the population residing in long-term care facilities or nursing homes and exclude residents in facilities providing only room and board or serving special health problems such as mental retardation or alcoholism.

Vaccination status is ascertained by the staff member completing the survey based on available records; sampled residents are not queried. In the 1995 NNHS, the percentage of sampled residents for whom vaccination status could not be ascertained was 21 percent for influenza vaccination and 43 percent for pneumococcal vaccination.

The percent vaccinated calculation will include persons with unknown vaccination status in the denominator. Improvements to administration of the survey will be made in 1999 to minimize the reporting of unknown vaccination status.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Appendix A for focus area contact information.



14-29f. Pneumococcal vaccine.

National Data Source	National Nursing Home Survey (NNHS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	20.11 (Immunization and Infectious Diseases), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	25 (1997).
Numerator	Number of persons in long-term care facilities and nursing homes reported to have ever received a pneumococcal vaccination.
Denominator	Number of persons in long-term facilities and nursing homes.
Population Targeted	U.S. resident population (see Comments).
Questions Used To Obtain the National Data	From the 1997 National Nursing Home Survey: ➤ <i>Has (Name) ever had a pneumococcal vaccine, that is, a pneumonia vaccination?</i>

Expected Periodicity	Biennial.
Comments	See Comments provided with objective 14-19e for more information.



Vaccine Safety

14-30. Reduce vaccine-associated adverse events.

14-30a. Eliminate vaccine-associated paralytic polio (VAPP).

National Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
State Data Source	National Notifiable Disease Surveillance System (NNDSS), CDC, EPO.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	5 (1997).
Numerator	Number of confirmed cases of vaccine-associated paralytic poliomyelitis.
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Suspected Polio Case Worksheet, Rev. 08/98.
Expected Periodicity	Annual.
Comments	A case definition for paralytic poliomyelitis is available from CDC. ¹

A confirmed case of vaccine-associated paralytic poliomyelitis is defined as a person who (1) was vaccinated 4 to 30 days prior to the onset of illness; (2) was exposed to someone vaccinated 4 to 75 days after oral polio vaccine (OPV) was fed to a recipient in contact with a patient, and contact occurred within 30 days before the onset of illness; or (3) had no history of receiving OPV or of contact with an OPV recipient, but the virus was isolated and characterized as vaccine-related. In addition, the person has a neurologic deficit 60 days after the onset of initial symptoms, has died, or has unknown followup status.

All suspected paralytic poliomyelitis cases are reviewed by an external committee and are classified following confirmation by this committee.

See Part C for a description of NNDSS and Appendix A for focus area contact information.



14-30b. Reduce febrile seizures following pertussis vaccines.

National Data Sources	Vaccine Adverse Event Reporting System (VAERS), HRSA, FDA, CDC; Vaccine Safety Datalink (VSD), CDC, NIP.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	152 (1998).
Numerator	Number of children with febrile seizures (observed or reported muscular contractions and loss of consciousness lasting from several minutes to more than 15 minutes and not accompanied by focal neurological signs or symptoms, with these seizures or convulsions associated with fever in children aged 0 to 9 years) that occur within 48 hours after receipt of a pertussis-containing vaccine.
Denominator	Not applicable.
Population Targeted	U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>In addition to incident cases of febrile seizures caused by pertussis vaccines, CDC monitors the net number of doses of pertussis-containing vaccines distributed by year and by type through the Biologics Survey to verify that reductions are not due to decreases in the number of vaccine doses administered.</p> <p>Estimates may also be available based on extrapolations from the National Immunization Survey.</p> <p>VAERS reports of febrile seizures are coded using Coding Terms for a Thesaurus of Adverse Reaction Terms (COSTART). VAERS is a passive surveillance system.</p> <p>See Appendix A for focus area contact information.</p>



14-31. Increase the number of persons under active surveillance for vaccine safety via large linked databases.

National Data Source	Vaccine Safety Datalink (VSD), CDC, NIP.
State Data Source	Vaccine Safety Datalink (VSD), CDC, NIP.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	6 million persons (1999).
Numerator	Number of persons enrolled in all health plans with large-linked databases in the past year.
Denominator	Number of persons.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.

Expected Periodicity	Not specified.
Comments	Data are collected from computer databases of participating health plans. Quality of health plan databases on vaccinations and medical encounters varies. See Appendix A for focus area contact information.



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15

Injury and Violence Prevention

Injury Prevention

- 15-1 Nonfatal head injuries
- 15-2 Nonfatal spinal cord injuries
- 15-3 Firearm-related deaths
- 15-4 Proper firearm storage in homes
- 15-5 Nonfatal firearm-related injuries
- 15-6 Child fatality review
- 15-7 Nonfatal poisonings
- 15-8 Deaths from poisoning
- 15-9 Deaths from suffocation
- 15-10 Emergency department surveillance systems
- 15-11 Hospital discharge surveillance systems
- 15-12 Emergency department visits

Unintentional Injury Prevention

- 15-13 Deaths from unintentional injuries
- 15-14 Nonfatal unintentional injuries
- 15-15 Deaths from motor vehicle crashes
- 15-15a Rate per 100,000 population
- 15-15b Rate per 100 million vehicle miles traveled
- 15-16 Pedestrian deaths
- 15-17 Nonfatal motor vehicle injuries
- 15-18 Nonfatal pedestrian injuries
- 15-19 Safety belts
- 15-20 Child restraints
- 15-21 Motorcycle helmet use
- 15-22 Graduated driver licensing
- 15-23 Bicycle helmet use

- 15-24 Bicycle helmet laws
- 15-25 Residential fire deaths
- 15-26 Functioning smoke alarms in residences
 - 15-26a Total population
 - 15-26b Residences
- 15-27 Deaths from falls
- 15-28 Hip fractures
 - 15-28a Females aged 65 years and older
 - 15-28b Males aged 65 years and older
- 15-29 Drownings
- 15-30 Dog bite injuries
- 15-31 Injury protection in school sports

Violence and Abuse Prevention

- 15-32 Homicides
- 15-33 Maltreatment and maltreatment fatalities of children
 - 15-33a Maltreatment
 - 15-33b Maltreatment fatalities
- 15-34 Physical assault by intimate partners
- 15-35 Rape or attempted rape
- 15-36 Sexual assault other than rape
- 15-37 Physical assaults
- 15-38 Physical fighting among adolescents
- 15-39 Weapon carrying by adolescents on school property

Injury Prevention

15-1. Reduce hospitalizations for nonfatal head injuries.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge systems.
Healthy People 2000 Objective	9.9 (Unintentional Injuries), age adjusted to 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	60.6 (1998).
Numerator	Number of hospitalizations for nonfatal head injuries (principal diagnosis of ICD-9-CM codes 800-801, 803-804, 850-854, 870-873, 925).
Denominator	Number of persons.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	From the 1998 National Hospital Discharge Survey: ➤ <i>Final Diagnoses (Including E-code diagnoses):</i> ➤ <i>Principal:</i>
Expected Periodicity	Annual.
Comments	Principal diagnosis is the diagnosis chiefly responsible for admission of the person to the hospital. Data are age-adjusted to the 2000 standard population. Age-adjusted rates are the weighted sums of age-specific rates. For a discussion of age adjustment see Part A, section 5. See Part C for a description of NHDS and Appendix A for focus area contact information.



15-2. Reduce hospitalizations for nonfatal spinal cord injuries.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge systems.
Healthy People 2000 Objective	9.10 (Unintentional Injuries), age adjusted to 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	4.5 (1998).
Numerator	Number of hospitalizations for nonfatal spinal cord injuries (principal diagnosis of ICD-9-CM codes 806, 952).
Denominator	Number of persons.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	From the 1998 National Hospital Discharge Survey: ➤ <i>Final Diagnoses (Including E-code diagnoses):</i> ➤ <i>Principal:</i>
Expected Periodicity	Annual.
Comments	Principal diagnosis is the diagnosis chiefly responsible for admission of the person to the hospital. Data are age-adjusted to the 2000 standard population. Age-adjusted rates are the weighted sums of age-specific rates. For a discussion of age adjustment see Part A, section 5. See Part C for a description of NHDS and Appendix A for focus area contact information.



15-3. Reduce firearm-related deaths.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
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State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	7.3 (Violent and Abusive Behavior), age adjusted to 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	11.3 (1998).
Numerator	Number of firearm-related deaths (ICD-9 codes E922, E955.0-E955.4, E965.0-E965.4, E970, E985.0-E985.4).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age-adjusted to the 2000 standard population. Age-adjusted rates are the weighted sums of age-specific rates. For a discussion of age adjustment see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 7.3, which adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



15-4. Reduce the proportion of persons living in homes with firearms that are loaded and unlocked.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	7.11 (Violent and Abusive Behavior), age adjusted to 2000 standard population.
Measure	Percent (age adjusted—see Comments).

Baseline	19 (1998).
Numerator	Number of persons aged 18 years and older who report living in homes with firearms loaded and unlocked.
Denominator	Number of persons aged 18 years and older who report living in homes with firearms.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>[NUMERATOR:]</p> <p>➤ <i>Is at least one of the firearms kept unloaded and unlocked?</i></p> <p>[DENOMINATOR:]</p> <p>➤ <i>Are any firearms now kept in or around your home? Include those kept in a garage, outdoor storage area, truck or car</i></p>
Expected Periodicity	Periodic.
Comments	<p>The questions for this objective are periodically included in supplements to NHIS. BRFSS items are collected in rotating modules (approximately every 3 years).</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment see Part A, section 5.</p> <p>See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.</p>



15-5. Reduce nonfatal firearm-related injuries.

National Data Source	National Electronic Injury Surveillance System (NEISS), CPSC.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population.

Baseline	24 (1997).
Numerator	Number of nonfatal firearm-related cases treated in U.S. hospital emergency department records.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	<p>A firearm-related injury is defined as a penetrating injury or gunshot wound from a weapon using a powder charge to fire a projectile.</p> <p>NEISS does not use ICD codes, however, reporters are given extensive training and report any gun-related injury cases in the emergency department record. Victims may also have other types of injuries, but if the incident involved a gun, it is included. Coders also attempt to capture data on intent, when appropriate information is provided in the medical record.</p> <p>See Appendix A for focus area contact information.</p>



15-6. (Developmental) Extend State-level child fatality review of deaths due to external causes for children aged 14 years and under.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>The proposed data source is the Inter-Agency Council on Child Abuse and Neglect (ICAN) National Database, FBI Uniform Crime Report, DOJ.</p> <p>See Appendix A for focus area contact information.</p>
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15-7. Reduce nonfatal poisonings.

National Data Source	National Hospital Ambulatory Medical Care Survey (NHAMCS), NCHS, CDC.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 9.8 (Unintentional Injuries).
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	348.4 (1997).
Numerator	Number of emergency room visits for nonfatal poisonings (first-listed ICD-9-CM codes E850-E869, E950-E952, E962, E972, E980-E982).
Denominator	Number of persons.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997-98 National Hospital Ambulatory Medical Care Survey:</p> <hr/> <p>➤ <i>Cause of injury. Describe events that preceded injury (e.g., reaction to penicillin, wasp sting, driver in motor vehicle traffic accident involving collision with parked vehicle, shot with a handgun during a brawl, etc.)</i></p> <hr/>
Expected Periodicity	Annual.
Comments	<p>Data include all emergency room visits related to poisoning regardless of intent (intentional, unintentional, and undetermined).</p> <p>This objective differs from Healthy People 2000 objective 9.8, which used data from NEISS, CPSC that were not age adjusted.</p>

The NHAMCS uses ICD-9-CM codes assigned to the cause of injury to identify poisoning cases in emergency department records, whereas NEISS used emergency department admissions related to a specific list of regulated products that were classified as poisons. Hence, NEISS data may have undercounted poisoning admissions. Additionally, when the list of regulated products changed, some cases previously classified as poisonings may have been omitted from the reported rate of poisoning admissions.

Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion of age adjustment see Part A, section 5.

See Part C for a description of NHAMCS and Appendix A for focus area contact information.



15-8. Reduce deaths caused by poisonings.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	6.8 (1998).
Numerator	Number of poisoning deaths (ICD-9 codes E850-E869, E950-E952, E962, E972, E980-E982).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments	<p>Data are age adjusted to the 2000 standard. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment see Part A, section 5.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>
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15-9. Reduce deaths caused by suffocation.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	4.1 (1998).
Numerator	Number of suffocation deaths (ICD-9 codes E911-E913, E953, E963, E983).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment see Part A, section 5.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



15-10. Increase the number of States and the District of Columbia with statewide emergency department surveillance systems that collect data on external causes of injury.

National Data Source	External Cause of Injury Survey, American Public Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	12 (1998).
Numerator	Number of States and the District of Columbia that “routinely collect” ICD-9-CM external cause of injury codes in their statewide hospital emergency department data system.
Denominator	Not applicable.
Population Targeted	Not applicable.
Questions Used To Obtain the National Data	From the 1998 How States Are Collecting and Using Cause of Injury Data Survey: ➤ <i>Are ICD-9-CM E-coded data routinely collected in the statewide hospital emergency department data system?</i>
Expected Periodicity	Periodic.
Comments	See Appendix A for focus area contact information.



15-11. Increase the number of States and the District of Columbia that collect data on external causes of injury through hospital discharge data systems.

National Data Source	External Cause of Injury Survey, American Public Health Association.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.

Measure	Number.
Baseline	23 (1998).
Numerator	Number of States and the District of Columbia that “mandate” the use of ICD-9-CM external cause of injury codes in their statewide hospital discharge data systems.
Denominator	Not applicable.
Population Targeted	Not applicable.
Questions Used To Obtain the National Data	From the 1998 How States Are Collecting and Using Cause of Injury Data Survey: ➤ <i>Is the collection of ICD-9-CM coded data in the statewide hospital discharge data system mandated by state law or a ruling by another body?</i>
Expected Periodicity	Periodic.
Comments	For this objective, the term “mandate” refers to a State law or a ruling by another body (for example, the State hospital association) that requires hospitals to collect data on ICD-9-CM external cause of injury codes and report them to a statewide hospital discharge data system. See Appendix A for focus area contact information.



15-12. Reduce hospital emergency department visits caused by injuries.

National Data Source	National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population (age adjusted—see Comments).
Baseline	131 (1997).
Numerator	Number of emergency department visits due to injury or poisoning.
Denominator	Number of persons.

Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997-98 National Hospital Ambulatory Medical Care Survey:</p> <ul style="list-style-type: none"> ➤ <i>Is this visit related to injury or poisoning?</i> ➤ <i>Cause of injury. Describe events that preceded injury (e.g., reaction to penicillin, wasp sting, driver in motor vehicle traffic accident involving collision with parked vehicle, shot with a handgun during a brawl, etc.)</i> <hr/> <hr/> ➤ <i>Patient's complaint(s), symptoms, or other reason(s) for this visit.</i> <ul style="list-style-type: none"> 1. Most important <hr/> 2. Other <hr/> 3. Other <hr/> ➤ <i>Physician's diagnoses for this visit.</i> <ul style="list-style-type: none"> 1. Primary diagnosis <hr/> 2. Other <hr/> 3. Other <hr/>

Expected Periodicity Annual.

Comments An emergency department visit was considered to be related to injury if “yes” was checked in the first question above or if a cause of injury, a nature of injury diagnosis, or an injury-related reason for visit coded to first listed ICD-9-CM codes E800-E869, E880-E929, E950-E999 was reported in the response to the other questions above.

Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion of age adjustment see Part A, section 5.

See Part C for a discussion of NHAMCS and Appendix A for focus area contact information.



Unintentional Injury Prevention

15-13. Reduce deaths caused by unintentional injuries.

National Data Source National Vital Statistics System (NVSS), CDC, NCHS.

State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	9.1 (Unintentional Injuries), age adjusted to 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	35.0 (1998).
Numerator	Number of deaths caused by unintentional injury (ICD-9 codes E800-E869, E880-E929).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 9.1, which adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



15-14. (Developmental) Reduce nonfatal unintentional injuries.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>This objective is adapted from Healthy People 2000 objective 9.2, which used data from the National Hospital Discharge System (NHDS), however, because of the underreporting of E-codes in NHDS, a new data source is needed.</p>
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Proposed national data sources are the National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS, and the National Electronic Injury Surveillance System (NEISS), CPSC.

See Part C for a description of NHAMCS and NEISS and Appendix A for focus area contact information.



15-15. Reduce deaths caused by motor vehicle crashes.

15-15a. Deaths per 100,000 population.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Adapted from 9.3 (Unintentional Injuries).
Leading Health Indicator	Injury and Violence.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	15.6 (1998).
Numerator	Number of unintentional injury traffic deaths (ICD-9 codes E810-E819).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment see Part A, section 5.

This objective differs from Healthy People 2000 objective 9.3, in that all data are age-adjusted data from NVSS. Data for objective 9.3 included both age-adjusted data from NVSS and crude rates from the Fatality Analysis Reporting System (FARS). In addition, the age-adjusted rates in objective 9.3 were adjusted to the 1940 standard population. See Appendix C for comparison data.

This objective is one of the measures used to track the Injury and Violence Leading Health Indicator. See Appendix H for a complete list.

See Part C for a description of NVSS and Appendix A for focus area contact information.



15-15b. Deaths per 100 million vehicle miles traveled (VMT).

National Data Sources	Fatality Analysis Reporting System (FARS), DOT, NHTSA; Highway Performance Monitoring System, DOT, FHWA.
State Data Sources	Fatality Analysis Reporting System (FARS), DOT, NHTSA; Highway Performance Monitoring System, DOT, FHWA.
Healthy People 2000 Objective	9.3 (Unintentional Injuries).
Measure	Rate per 100 million vehicle miles traveled (VMT).
Baseline	1.6 (1998).
Numerator	Number of motor vehicle crash deaths reported in FARS.
Denominator	Total vehicle miles traveled.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments	<p>FARS uses multiple data sources, including police reports, death certificates, and others. Race data were not collected in FARS until 1999. These data will be included in the data presentation for this objective when they become available for analysis.</p> <p>The FHWA estimates total vehicle miles traveled using an algorithm that includes gas sales, vehicle registration, vehicle fuel economy data, and other data from the Highway Performance Monitoring System.</p> <p>See Appendix A for focus area contact information.</p>
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15-16. Reduce pedestrian deaths on public roads.

National Data Source	Fatality Analysis Reporting System (FARS), DOT, NHTSA.
State Data Source	Fatality Analysis Reporting System (FARS), DOT, NHTSA.
Healthy People 2000 Objective	9.3f (Unintentional Injuries).
Measure	Rate per 100,000 population.
Baseline	1.9 (1998).
Numerator	Number of pedestrian deaths reported in FARS.
Denominator	Number of persons.
Population Targeted	U.S. resident population
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>FARS uses multiple sources, including police reports, death certificates (coded to ICD-9 E810-E819), and other sources. FARS data do not include pedestrian deaths on private roadways, such as driveways. Driveways are a common location for pedestrian deaths for pedestrians aged 0-2 years.</p> <p>See Appendix A for focus area contact information.</p>

15-17. Reduce nonfatal injuries caused by motor vehicle crashes.

National Data Source	General Estimates System (GES), DOT, NHTSA.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population.
Baseline	1,181 (1998).
Numerator	Number of nonfatal motor vehicle crash-related injuries reported in police reports.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>GES data are from a nationally representative sample of police-reported motor vehicle crashes. To be included, the crash must involve a motor vehicle traveling on a traffic way and involve property damage, injury, or death.</p> <p>See Appendix A for focus area contact information.</p>



15-18. Reduce nonfatal pedestrian injuries on public roads.

National Data Source	General Estimates System (GES), DOT, NHTSA.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population.
Baseline	26 (1998).
Numerator	Number of nonfatal pedestrian injuries reported in police reports.
Denominator	Number of persons.

Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>GES data are from a nationally representative sample of police-reported motor vehicle crashes. To be included, the crash must involve a motor vehicle traveling on a traffic way and involve property damage, injury, or death.</p> <p>See Appendix A for focus area contact information.</p>



15-19. Increase use of safety belts.

National Data Source	National Occupant Protection Use Survey (NOPUS), DOT, NHTSA.
State Data Source	Not identified.
Healthy People 2000 Objective	9.12 (Unintentional Injuries).
Measure	Percent.
Baseline	69 (1998).
Numerator	Number of persons observed using restraints.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Biennial.
Comments	NOPUS uses observational data collected at intersections, highway ramps, and parking lots. Four observers (each responsible for a different seat in the vehicle) report occupant restraint use.

The data for students in grades 9 through 12 are tracked separately with the Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP (see Part C for a discussion of YRBSS). The numerator for that measure is the number of students in grades 9 through 12 who report that they wore a seat belt sometimes, most of the time, or always when they were riding in a car. The denominator is the number of students in grades 9 through 12. The questions from the 1999 Youth Risk Behavior Survey follow:

➤ *How often do you wear a seat belt when riding in a car driven by someone else?*

Never Rarely Sometimes Most of the time Always

See Appendix A for focus area contact information.



15-20. Increase use of child restraints.

National Data Source	National Occupant Protection Use Survey (NOPUS), Controlled Intersection Study, DOT, NHTSA.
State Data Source	Not identified.
Healthy People 2000 Objective	9.12 (Unintentional Injuries).
Measure	Percent.
Baseline	92 (1998).
Numerator	Number of children aged 4 and under observed in safety seats or restraints.
Denominator	Number of children aged 4 years and under.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Biennial.
Comments	NOPUS uses observational data collected at intersections, highway ramps, and parking lots. Four observers (each responsible for a different seat in the vehicle) report occupant restraint use.



15-21. Increase the proportion of motorcyclists using helmets.

National Data Source	National Occupant Protection Use Survey (NOPUS), DOT, NHTSA.
State Data Source	Not identified.
Healthy People 2000 Objective	9.13 (Unintentional Injuries).
Measure	Percent.
Baseline	67 (1998).
Numerator	Number of motorcyclists observed wearing helmets.
Denominator	Number of motorcycle operators and passengers observed.
Population Targeted	Motorcycle operators and passengers.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Biennial.
Comments	<p>NOPUS uses observational data collected at intersections, highway ramps, and parking lots. Four observers (each responsible for a different seat in cars, two observers for motorcycles) report occupant helmet use.</p> <p>The data for students in grades 9 through 12 come from the Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP (see Part C for a discussion of YRBSS). The numerator for that measure is the number of students in grades 9 through 12 who report that they sometimes, most of the time, <u>or</u> always wore a helmet when riding a motorcycle. The denominator is the number of students in grades 9 through 12 who report that they rode a motorcycle at least once in the past 12 months. The questions from the 1999 Youth Risk Behavior Survey are:</p>

- *During the past 12 months, how many times did you ride a motorcycle?*

0 times
1 to 10 times
11 to 20 times
21 to 39 times
40 or more times

- *When you rode a motorcycle during the past 12 months, how often did you wear a helmet?*

I did not ride a motorcycle during the past 12 months
Never wore a helmet
Rarely wore a helmet
Sometimes wore a helmet
Most of the time wore a helmet
Always wore a helmet

See Appendix A for focus area contact information.



15-22. Increase the number of States and the District of Columbia that have adopted a graduated driver licensing model law.

National Data Source	U.S. Licensing Systems for Young Drivers, Insurance Institute for Highway Safety.
State Data Source	Not identified.
Healthy People 2000 Objective	9.26 (Unintentional Injuries).
Measure	Number.
Baseline	23 (1999).
Numerator	Number of jurisdictions with the core components.
Denominator	Not applicable.
Population Targeted	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

Core components are noted in the National Committee on Uniform Traffic Laws and Ordinances (NCUTLO) model law and include 6 months in the learner stage and 6 months in the intermediate driving stage with night-driving restrictions. Participants are also required to have no safety belt violations and to be conviction free during the holding periods. Data are compiled by periodic review of laws for the presence of these components.

See Appendix A for focus area contact information.

**15-23. (Developmental) Increase use of helmets by bicyclists.****Comments**

An operational definition could not be specified at the time of publication.

Proposed national data sources include CPSC, the Behavioral Risk Factor Surveillance System, and the World Health Organization Study of Health Behavior in School Children.

This objective is modified from Healthy People objective 9.13, which used data from the National Occupant Protection Use Survey.

See Appendix A for focus area contact information.

**15-24. Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders.**

National Data Source	National Safe Kids Campaign.
State Data Source	Not identified.
Healthy People 2000 Objective	9.24 (Unintentional Injuries).
Measure	Number.
Baseline	10 (1999).

Numerator	Number of States and the District of Columbia with bicycle helmet laws.
Denominator	Not applicable.
Population Targeted	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>This objective differs from Healthy People 2000 objective 9.24, in that the laws counted apply to the entire State; objective 9.24 included some data for which only parts of States (counties) were covered.</p> <p>See Appendix A for focus area contact information.</p>



15-25. Reduce residential fire deaths.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	9.6 (Unintentional Injuries), age adjusted to 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	1.2 (1998).
Numerator	Number of unintentional fire-related injury deaths (ICD-9 codes E890-E899)
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	A small proportion of the deaths reported may have occurred in locations other than residences.

Data are age adjusted to the 2000 standard. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment see Part A, section 5.

This objective differs from Healthy People 2000 objective 9.6, which adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.

See to Part C for a description of NVSS and Appendix A for focus area contact information.



15-26. Increase functioning residential smoke alarms.

15-26a. Total population living in residences with functioning smoke alarm on every floor.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	9.17 (Unintentional Injuries), age adjusted to 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	88 (1998).
Numerator	Number of persons aged 18 years and older who report living in residences with functional smoke alarms on each habitable floor.
Denominator	Number of persons aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey: ➤ <i>Do you have at least one working smoke detector on each floor of your home? Include a finished basement or attic.</i>
Expected Periodicity	Periodic.

Comments

The data for this objective are based on the response of one adult per household. The response of the adult household respondent is applied to all members of the household.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment see Part A, section 5.

See Part C for a description of NHIS and Appendix A for focus area contact information.

**15-26b. Residences with a functioning smoke alarm on every floor.**

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 9.17 (Unintentional Injuries).
Measure	Percent.
Baseline	87 (1998).
Numerator	Number households with functional smoke alarms on each habitable floor of their residence.
Denominator	Number of households.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey: ➤ <i>Do you have at least one working smoke detector on each floor of your home? Include a finished basement or attic.</i>
Expected Periodicity	Periodic.
Comments	The data for this objective are based on the response of one adult per household. The response of the adult household respondent is considered the response for one "household."

This objective differs from Healthy People 2000 objective 9.17, which tracked the proportion of residences with smoke detectors using data from Rodale Press and CPSC.

See Part C for a description of NHIS and Appendix A for focus area contact information.



15-27. Reduce deaths from falls.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	9.4 (Unintentional Injuries), age adjusted to 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	4.7 (1998).
Numerator	Number of unintentional deaths from falls (ICD-9 codes E880-E886, E888).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 9.4, which adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>

15-28. Reduce hip fractures among older adults.

15-28a. Females aged 65 years and older.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge systems.
Healthy People 2000 Objective	9.7 (Unintentional Injuries), age adjusted to 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	1,055.8 (1998).
Numerator	Number of hospitalizations for hip fractures (principal diagnosis of ICD-9-CM code 820) among females aged 65 years and older.
Denominator	Number of females aged 65 years and older.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	<p>From the 1998 National Hospital Discharge Survey:</p> <ul style="list-style-type: none">➤ <i>Final diagnoses (including E-code diagnoses):</i>➤ <i>Principal:</i>
Expected Periodicity	Annual.
Comments	<p>Principal diagnosis is the diagnosis chiefly responsible for admission of the person to the hospital.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion of age adjustment see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 9.7, which measured hip fractures for the total population and did not have two separate measures for males and females. In addition, the data for this objective are age adjusted.</p> <p>See Part C for a description of NHDS and Appendix A for focus area contact information.</p>



15-28b. Males aged 65 years and older.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge systems.
Healthy People 2000 Objective	9.7 (Unintentional Injuries), age adjusted to 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	592.7 (1998).
Numerator	Number of hip fractures (principal ICD-9-CM code 820) among males aged 65 years and older.
Denominator	Number of males aged 65 years and older.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	From the 1998 National Hospital Discharge Survey: <ul style="list-style-type: none">➤ <i>Final diagnoses (including E-code diagnoses):</i>➤ <i>Principal:</i>
Expected Periodicity	Annual.
Comments	See Comments provided with objective 8-28a for more information.



15-29. Reduce drownings.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	9.5 (Unintentional Injuries), age adjusted to 2000 standard population.
Measure	Rate per 100,000 (age adjusted—see Comments).
Baseline	1.6 (1998).
Numerator	Number of drowning deaths (ICD-9 codes E830, E832, E910).

Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 9.5, which adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



15-30. Reduce hospital emergency department visits for nonfatal dog bite injuries.

National Data Source	National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	151.4 (1997).
Numerator	Number of emergency room visits for dog bite injuries (first-listed ICD-9-CM codes E906.0).
Denominator	Number of persons.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997-98 National Hospital Ambulatory Medical Care Survey:

- *Cause of injury. Describe events that preceded injury (e.g., reaction to penicillin, wasp sting, driver in motor vehicle traffic accident involving collision with parked vehicle, shot with a handgun during a brawl, etc.)*
-

Expected Periodicity

Annual.

Comments

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment see Part A, section 5.

See Part C for a discussion of NHAMCS and Appendix A for focus area contact information.



15-31. (Developmental) Increase the proportion of public and private schools that require use of appropriate head, face, eye, and mouth protection for students participating in school-sponsored physical activities.

Comments

An operational definition could not be specified at the time of publication. The proposed national data source is the School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

The expected numerator is the number of schools that require students to wear appropriate protective gear when engaged in physical activities during physical education, intramural activities, physical activity clubs, and interscholastic sports. The expected denominator is the number of schools with intramural activities or physical activity clubs and interscholastic sports.

The expected questions to be used to obtain data from the 2000 School Health Policies and Programs Study, Physical Education Questionnaire follow:

- *Must students wear appropriate protective gear when engaged in physical activities during physical education?*
- *Must students wear appropriate protective gear when engaged in intramural activities or physical activity clubs?*
- *Must students wear appropriate protective gear when engaged in interscholastic sports?*

This objective is adapted from Healthy People 2000 objective 9.19 (also 13.16), which was tracked with proxy data from the National Healthy Interview Survey (NHIS), CDC, NCHS.

See Appendix A for focus area contact information.



Violence and Abuse Prevention

15-32. Reduce homicides.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	7.1 (Violent and Abusive Behavior), age adjusted to 2000 standard population.
Leading Health Indicator	Injury and Violence.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	6.5 (1998).
Numerator	Number of deaths due to homicides (ICD-9 codes E960-E969).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 7.1, which adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p>

This measure also differs slightly from the cause of death, homicide and legal intervention (ICD-9 E960-E978), which is shown in other publications.^{1, 2}

This objective is one of the measures used to track the Injury and Violence Leading Health Indicator. See Appendix H for a complete list.

See Part C for a description of NVSS and Appendix A for focus area contact information.



15-33. Reduce maltreatment and maltreatment fatalities of children.

15-33a. Reduce maltreatment of children.

National Data Source	National Child Abuse and Neglect Data System (NCANDS), Summary Data Component Survey, ACYF, ACF.
State Data Source	State data reports of maltreatment from State child welfare agencies.
Healthy People 2000 Objective	Adapted from 7.4 (Violent and Abusive Behavior).
Measure	Rate per 1,000 population.
Baseline	12.9 (1998).
Numerator	Number of children aged 18 years and under found to be victims of maltreatment by State child welfare agencies.
Denominator	Children aged 18 years and under.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	From the 1999 State Data Component Survey: ➤ <i>Enter the number of children by disposition who were the subject of a CPS investigation or assessment</i> _____.
Expected Periodicity	Annual.

Comments

Maltreatment is defined as an act or failure to act by a parent, caretaker, other person, as defined under State law, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act that presents an imminent risk of serious harm. State definitions may include additional criteria.

This objective differs from Healthy People 2000 objective 7.4 in that it is counting children who have been abused; objective 7.4 counted "reports" of abuse.

See Appendix A for focus area contact information.

**15-33b. Reduce child maltreatment fatalities.**

National Data Source	National Child Abuse and Neglect Data System (NCANDS), Summary Data Component Survey, ACYF, ACF.
State Data Source	State data reports of maltreatment from State child welfare agencies.
Healthy People 2000 Objective	Adapted from 7.4 (Violent and Abusive Behavior).
Measure	Rate per 100,000 population.
Baseline	1.6 (1998).
Numerator	Number of reported child fatalities due to maltreatment among children aged 18 years and under.
Denominator	Children aged 18 years and under.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	From the 1999 State Data Component Survey: ➤ <i>Enter the number of child victims who died as a result of child abuse or neglect ____.</i>
Expected Periodicity	Annual.

Comments

Child fatality due to maltreatment is defined as the death of a child as a result of abuse or neglect, because either (a) an injury resulting from the abuse or neglect of a child was the cause of the death, or (b) abuse and/or neglect were contributing factors to the cause of death. Data on child fatalities are collected from all States; some State offices of child protective services work closely with Health Departments or the coroner's office, whereas others rely more on their own records, including deaths reported to them by law enforcement.

This objective differs from Healthy People 2000 objective 7.4 in that it measures fatalities due to child maltreatment. Objective 7.4 measured reports of child maltreatment.

See Appendix A for focus area contact information.

**15-34. Reduce the rate of physical assault by current or former intimate partners.**

National Data Source	National Crime Victimization Survey (NCVS), DOJ, BJS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 7.5 (Violent and Abusive Behavior).
Measure	Rate per 1,000 population.
Baseline	4.4 (1998).
Numerator	Number of persons aged 12 years and older who report being threatened or assaulted by current or former spouse, boyfriend, or girlfriend.
Denominator	Number of persons aged 12 years and older.
Population Targeted	Noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Crime Victimization Survey:

- *Other than any incidents already mentioned, has anyone attacked or threatened you in any of these ways:*
 - a) *With any weapon, for instance, a gun or knife*
 - b) *With anything like a baseball bat, frying pan, scissors or stick*
 - c) *By something thrown, such as a rock or bottle*
 - d) *Include any grabbing, punching, or choking*
 - e) *Any rape, attempted rape or other type of sexual attack*
 - f) *Any face-to-face threats*

OR

 - g) *Any attack or threat or use of force by anyone at all? Please mention it even if you are not certain that it was a crime.*
- (Briefly describe incident.)*
- *People often don't think of incidents committed by someone they know. (Other than incidents already mentioned) did you have something stolen from you OR were you attacked or threatened by (Exclude telephone threats)...*
 - a) *Someone at work or school*
 - b) *A neighbor or friend*
 - c) *A relative or family member*
 - d) *Any other person you've met or known?*

(Briefly describe incident.)

Expected Periodicity

Annual.

Comments

This objective differs from Healthy People 2000 objective 7.5, which included females only.

See Part C for a description of NCVS and Appendix A for focus area contact information.



15-35. Reduce the annual rate of rape or attempted rape.

National Data Source

National Crime Victimization Survey (NCVS), DOJ, BJS.

State Data Source

Not identified.

Healthy People 2000 Objective

Adapted from 7.7 (Violent and Abusive Behavior).

Measure

Rate per 1,000 population.

Baseline

0.8 (1998).

Numerator	Number of persons aged 12 years and older who reported being raped or a victim of an attempted rape.
Denominator	Number of persons aged 12 years and older.
Population Targeted	Noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Crime Victimization Survey:</p> <p>➤ <i>Other than any incidents already mentioned, has anyone attacked or threatened you in any of these ways:</i></p> <p>[Response categories include:] <i>Any rape, attempted rape, or other type of sexual attack?</i></p> <p><i>(Briefly describe the incident.)</i></p>
Expected Periodicity	Annual.
Comments	<p>This objective differs from Healthy People 2000 objective 7.7, which included females only.</p> <p>See Part C for a description of NCVS and Appendix A for focus area contact information.</p>



15-36. Reduce sexual assault other than rape.

National Data Source	National Crime Victimization Survey (NCVS), U. S. Department of Justice, Bureau of Justice Statistics.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population.
Baseline	0.6 (1998).
Numerator	Number of persons aged 12 years and older who report being threatened or physically assaulted in a sexual way other than rape.
Denominator	Number of persons aged 12 years and older.
Population Targeted	Noninstitutionalized population.

Questions Used To Obtain the National Data

From the 1998 National Crime Victimization Survey:

- *Other than any incidents already mentioned, has anyone attacked or threatened you in any of these ways:*

[Response categories include:]

Any rape, attempted rape, or other type of sexual attack?

(Briefly describe the incident.)

Expected Periodicity

Annual.

Comments

Sexual assaults include sexual attacks or threats other than rape or attempted rape against males and females.

See Part C for a description of NCVS and Appendix A for focus area contact information.



15-37. Reduce physical assaults.

National Data Source

National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics.

State Data Source

Not identified.

Healthy People 2000 Objective

Adapted from 7.6 (Violent and Abusive Behavior).

Measure

Rate per 1,000 population.

Baseline

31.1 (1998).

Numerator

Number of persons aged 12 years and older who report being physically assaulted.

Denominator

Number of persons aged 12 years and older.

Population Targeted

Noninstitutionalized population.

Questions Used To Obtain the National Data

From the 1998 National Crime Victimization Survey:

- *Other than any incidents already mentioned, has anyone attacked or threatened you in any of these ways:*
- a) With any weapon, for instance, a gun or knife*
 - b) With anything like a baseball bat, frying pan, scissors, or stick*
 - c) By something thrown, such as a rock or bottle*
 - d) Include any grabbing, punching, or choking*
 - e) Any rape, attempted rape or other type of sexual attack*
 - f) Any face-to-face threats*
- OR*
- g) Any attack or threat or use of force by anyone at all? Please mention it even if you are not certain that it was a crime.*
- (Briefly describe incident.)*

Expected Periodicity	Annual.
Comments	<p>This objective is modified from Healthy People 2000 objective 7.6, which tracked assault injuries. This objective tracks reports of assaults.</p> <p>See Part C for a description of NCVS and Appendix A for focus area contact information.</p>



15-38. Reduce physical fighting among adolescents.

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 7.9 (Violent and Abusive Behavior).
Measure	Percent.
Baseline	36 (1999).
Numerator	Number of students in grades 9 through 12 who report being in a physical fight at least 1 time during the 12 months preceding the survey.
Denominator	Students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.

Questions Used To Obtain the National Data

From the 1999 Youth Risk Behavior Surveillance System:

- *During the past 12 months, how many times were you in a physical fight?*

*0 times
1 time
2 or 3 times
4 or 5 times
6 or 7 times
8 or 9 times
10 or 11 times
12 or more times*

Expected Periodicity

Biennial.

Comments

This objective differs from Healthy People 2000 objective 7.9 in that it measures prevalence; objective 7.9 measured incidence.

See Part C for a description of YRBSS and Appendix A for focus area contact information.



15-39. Reduce weapon carrying by adolescents on school property.

National Data Source

Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

State Data Source

Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Healthy People 2000 Objective

Adapted from 7.10 (Violent and Abusive Behavior).

Measure

Percent.

Baseline

6.9 (1999).

Numerator

Number of students in grades 9 through 12 who report carrying a weapon on school property at least 1 day in the 30 days preceding the survey.

Denominator

Students in grades 9 through 12.

Population Targeted

Students in grades 9 through 12.

Questions Used To Obtain the National Data

From the 1999 Youth Risk Behavior Surveillance System:

- During the past 30 days, on how many days did you carry a weapon, such as a gun, knife, or club on school property?

0 days

1 day

2 or 3 days

4 or 5 days

6 or more days

Expected Periodicity Biennial.

Comments This objective differs from Healthy People 2000 objective 7.10 in that it is limited to weapon carrying on school grounds; objective 7.10 tracked weapon carrying in any location.

See Part C for a description of YRBSS and Appendix A for focus area contact information.



References

1. Hoyert, D.L.; Kochanek, K.D.; and Murphy, S.L. Deaths: Final data for 1997. *National Vital Statistics Reports*. Vol. 47 No. 19. Hyattsville, MD: National Center for Health Statistics (NCHS), 1999.
2. NCHS. *Health, United States, 2000, With Adolescent Health Chartbook*. Hyattsville, MD: NCHS, 2000.

16

Maternal, Infant, and Child Health

Fetal, Infant, Child, and Adolescent Deaths

- 16-1 Fetal and infant deaths
 - 16-1a At 20 or more weeks of gestation
 - 16-1b Perinatal deaths
 - 16-1c Infant deaths
 - 16-1d Neonatal deaths
 - 16-1e Postneonatal deaths
 - 16-1f All birth defects
 - 16-1g Congenital heart defects
 - 16-1h SIDS deaths
- 16-2 Child deaths
 - 16-2a Children aged 1 to 4 years
 - 16-2b Children aged 5 to 9 years
- 16-3 Adolescent and young adult deaths
 - 16-3a Adolescents aged 10 to 14 years
 - 16-3b Adolescents aged 15 to 19 years
 - 16-3c Young adults aged 20 to 24 years

Maternal Deaths and Illnesses

- 16-4 Maternal deaths
- 16-5 Maternal illness and complications due to pregnancy
 - 16-5a During labor and delivery
 - 16-5b Ectopic pregnancies
 - 16-5c Postpartum complications

Prenatal Care

- 16-6 Prenatal care
- 16-6a First trimester
- 16-6b Early and adequate
- 16-7 Childbirth classes

Obstetrical Care

- 16-8 Very low birth weight infants born at level III hospitals
- 16-9 Cesarean births
- 16-9a First-time births
- 16-9b Prior cesarean deliveries

Risk Factors

- 16-10 Low birth weight and very low birth weight
- 16-10a Low birth weight
- 16-10b Very low birth weight
- 16-11 Preterm births
- 16-11a Total preterm
- 16-11b 32 to 36 weeks of gestation
- 16-11c Less than 32 weeks of gestation
- 16-12 Weight gain during pregnancy
- 16-13 Infants put to sleep on their backs

Developmental Disabilities and Neural Tube Defects

- 16-14 Developmental disabilities
- 16-14a Mental retardation
- 16-14b Cerebral palsy
- 16-14c Autism
- 16-14d Epilepsy
- 16-15 Spina bifida and other neural tube defects
- 16-16 Optimum folic acid levels
- 16-16a Folic acid consumption
- 16-16b Median RBC folate levels

Prenatal Substance Exposure

- 16-17 Prenatal substance exposure
- 16-17a Alcohol
- 16-17b Binge drinking
- 16-17c Cigarette smoking
- 16-17d Illicit drugs
- 16-18 Fetal alcohol syndrome

Breastfeeding, Newborn Screening, and Service Systems

- 16-19 Breastfeeding
 - 16-19a Early postpartum
 - 16-19b At 6 months
 - 16-19c At 1 year
- 16-20 Newborn bloodspot screening
 - 16-20a Screening at birth
 - 16-20b Followup diagnostic testing
 - 16-20c Appropriate service interventions
- 16-21 Sepsis among children with sickle cell disease
- 16-22 Medical homes for children with special health care needs
- 16-23 Service systems for children with special health care needs

Fetal, Infant, Child, and Adolescent Deaths

16-1. Reduce fetal and infant deaths.

16-1a. Fetal deaths at 20 or more weeks of gestation.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	14.2 (Maternal and Infant Health).
Measure	Rate per 1,000 live births plus fetal deaths.
Baseline	6.8 (1997).
Numerator	Number of fetal deaths (20 or more weeks of gestation).
Denominator	Number of live births plus fetal deaths (20 or more weeks gestation).
Targeted Population	U.S. resident live births plus fetal deaths (20 or more weeks gestation).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A description of the primary measurement used to determine the infant's gestational age—the interval between the first day of the last normal menstrual period (LMP) and the birth—has been published by NCHS.¹</p> <p>This objective uses the same measurement protocol as the comparable Healthy People 2000 objective 14.2. A description of the fetal death measurement has been published by NCHS.²</p>

States are required to report fetal deaths if they occur in the 20th week of pregnancy or later, or if they weigh at least 350 grams.³ The number of fetal deaths may be underreported in part because of variations in reporting requirements by States.

See Part C for a description of NVSS and Appendix A for focus area contact information.



16-1b. Fetal and infant deaths during perinatal period (28 weeks of gestation to 7 days or more after birth).

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 live births plus fetal deaths.
Baseline	7.5 (1997).
Numerator	Number of fetal and infant deaths (from 28 weeks gestation to 7 days after birth).
Denominator	Number of live births plus fetal deaths (of at least 28 weeks gestation).
Targeted Population	U.S. resident live births plus fetal deaths (20 or more weeks gestation).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The number of fetal deaths may be underreported in part because of variations in reporting requirements by States.</p> <p>A description of the primary measurement used to determine the infant's gestational age—the interval between the first day of the last normal menstrual period (LMP) and the birth—has been published by NCHS.¹</p>

A description of the perinatal death measurement has been published by NCHS.³

See Part C for a description of NVSS and Appendix A for focus area contact information.



16-1c. All infant deaths (within 1 year).

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	14.1 (Maternal and Infant Health).
Measure	Rate per 1,000 live births.
Baseline	7.2 (1998).
Numerator	Number of deaths to infants under age 1 year.
Denominator	Number of live births.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	This objective uses a similar measurement protocol as the comparable Healthy People 2000 objective; however, all of the baseline data for this objective come from the period-linked birth and infant death data set (linked file). ⁴ In the linked file, the information from the death certificate is linked to information on the birth certificate for each infant under 1 year who died during the calendar year. The purpose of linkage is to use the many variables and improve racial/ethnic reporting available from the birth certificate. The comparable Healthy People 2000 objective was tracked using the annual “unlinked” file ⁵ for the total and black population, and the cohort (used from 1983–91) or period-(used since 1995) linked file for the American Indian/Alaska Native and Puerto Rican populations. ²

See Part C for a description of NVSS and Appendix A for focus area contact information.



16-1d. Neonatal deaths (within the first 28 days of life).

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	14.1d (Maternal and Infant Health).
Measure	Rate per 1,000 live births.
Baseline	4.8 (1998).
Numerator	Number of deaths infants aged under 28 days.
Denominator	Number of live births.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 16-1c for more information. See Part C for a description of NVSS and Appendix A for focus area contact information.



16-1e. Postneonatal deaths (between 28 days and 1 year).

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	14.1g (Maternal and Infant Health).
Measure	Rate per 1,000 live births.

Baseline	2.4 (1998).
Numerator	Number of deaths to infants aged 28 days to 11 months.
Denominator	Number of live births.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 16-1c for more information. See Part C for a description of NVSS and Appendix A for focus area contact information.



16-1f. All birth defects.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 live births.
Baseline	1.6 (1998).
Numerator	Number of infant (under age 1 year) deaths due to birth defects (ICD-9 codes 740-759).
Denominator	Number of live births.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments	<p>All of the baseline data for this objective come from the period-linked birth and infant death data set (linked file).⁴ In the linked file, the information from the death certificate is linked to information on the birth certificate for each infant under 1 year who died during the calendar year. The purpose of linkage is to use the many variables and improve racial/ethnic reporting available from the birth certificate.</p> <p>See Part C for a description of the NVSS and Appendix A for focus area contact information.</p>
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16-1g. Congenital heart defects.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 live births.
Baseline	0.53 (1998).
Numerator	Number of infant (under age 1 year) deaths from congenital heart and vascular defects (ICD-9 codes 745-747).
Denominator	Number of live births.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>See Comments provided with objective 16-1f for more information.</p> <p>ICD-9 codes 745-746 refer to congenital anomalies of the heart, and code 747 refers to other congenital anomalies of the circulatory system.</p>

See Part C for a description of NVSS and Appendix A for focus area contact information.



16-1h. Reduce deaths from sudden infant death syndrome (SIDS).

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 live births.
Baseline	0.72 (1998).
Numerator	Number of infant (under age 1 year) deaths from SIDS (ICD-9 code 798.0).
Denominator	Number of live births.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 16-1f for more information. See Part C for a description of NVSS and Appendix A for focus area contact information.



16-2. Reduce the rate of child death.

16-2a. Children aged 1 to 4 years.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.

Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population.
Baseline	34.6 (1998).
Numerator	Number of deaths among children aged 1 to 4 years.
Denominator	Number of children aged 1 to 4 years.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



16-2b. Children aged 5 to 9 years.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population.
Baseline	17.7 (1998).
Numerator	Number of deaths among children aged 5 to 9 years.
Denominator	Number of children aged 5 to 9 years.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



16-3. Reduce deaths of adolescents and young adults.

16-3a. Adolescents aged 10 to 14 years.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population.
Baseline	22.1 (1998).
Numerator	Number of deaths among adolescents aged 10 to 14 years.
Denominator	Number of adolescents aged 10 to 14 years.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



16-3b. Adolescents aged 15 to 19 years.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population.
Baseline	70.6 (1998).
Numerator	Number of deaths among adolescents aged 15 to 19 years.
Denominator	Number of adolescents aged 15 to 19 years.

Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



16-3c. Young adults aged 20 to 24 years.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population.
Baseline	95.3 (1998).
Numerator	Number of deaths among young adults aged 20 to 24 years.
Denominator	Number of young adults aged 20 to 24 years.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



Maternal Deaths and Illnesses

16-4. Reduce maternal deaths.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	14.3 (Maternal and Infant Health).
Measure	Ratio per 100,000 live births.
Baseline	7.1 (1998).
Numerator	Number of female deaths due to obstetric causes (ICD-9 codes 630 to 676) within 42 days of a pregnancy.
Denominator	Number of live births.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Caution should be used when comparing these data with pregnancy-related mortality rates from other reports. NCHS uses the definition of maternal mortality and related coding conventions recommended in the ICD-9 by the World Health Organization. Other definitions may use different time intervals from pregnancy to death and may be more inclusive with regard to cause of death.</p> <p>A description of the maternal mortality measurement has been published by NCHS.²</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



16-5. Reduce maternal illness and complications due to pregnancy.

16-5a. Maternal complications during hospitalized labor and delivery.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge data systems.
Healthy People 2000 Objective	Adapted from 14.7 (Maternal and Infant Health).
Measure	Rate per 100 deliveries.
Baseline	31.2 (1998).
Numerator	Number of hospital discharges for females with any listed diagnosis of maternal complications during labor/delivery (see Comments).
Denominator	Number of hospital discharges for females who delivered one or more infants (principal diagnosis of ICD-9-CM code V27).
Targeted Population	U.S. civilian population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>This objective was adapted from Healthy People 2000 objective 14.7, which measured “severe complications of pregnancy,” defined as hospitalizations for ICD-9-CM codes 630-676 (excluding 635 and 650).² The data used to track this Healthy People 2010 objective use any listed diagnosis of selected ICD-9-CM codes 641-672 (see Appendix E for a detailed list of codes used).</p> <p>Principal diagnosis is the diagnosis chiefly responsible for admission of the person to the hospital.</p> <p>See Part C for a description of NHDS and Appendix A for focus area contact information.</p>



16-5b. (Developmental) Ectopic pregnancies.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed data source is the National Hospital Discharge Survey (NHDS), CDC, NCHS.</p> <p>See Part C for a description of NHDS and Appendix A for focus area contact information.</p>
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16-5c. (Developmental) Postpartum complications, including postpartum depression.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>See Appendix A for focus area contact information.</p>
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Prenatal Care

16-6. Increase the proportion of pregnant women who receive early and adequate prenatal care.

16-6a. Care beginning in first trimester of pregnancy.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Leading Health Indicator	Access to Care.
Healthy People 2000 Objective	14.11 (Maternal and Infant Health).
Measure	Percent of live births.
Baseline	83 (1998).
Numerator	Number of females receiving prenatal care in the first trimester (three months) of pregnancy.

Denominator	Number of live births.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A description of the primary measurement used to determine the fetus's gestational age—the interval between the first day of the last normal menstrual period (LMP) and the birth—has been published by NCHS.¹</p> <p>This objective uses the same measurement protocol as the comparable Healthy People 2000 objective 14.11. A description of the prenatal care measurement has been published by NCHS.²</p> <p>This objective is one of the measures used to track the Access to Care Leading Health Indicator. See Appendix H for a complete listing.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



16-6b. Early and adequate prenatal care.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Percent of live births.
Baseline	74 (1998).
Numerator	Number of pregnant females receiving adequate prenatal care (by the Adequacy of Prenatal Care Utilization Index, APNCU).
Denominator	Number of live births.
Targeted Population	U.S. resident population.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The APNCU is a measure of prenatal care utilization that combines the month of pregnancy prenatal care begun with the number of prenatal visits. Rates can be classified as “intensive use,” “adequate,” “intermediate,” or “less than adequate.” For this objective, adequate prenatal care is defined as a score of either “adequate” or “intensive use.” A discussion of the APNCU has been published in a previous article.⁶</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



16-7. (Developmental) Increase the proportion of pregnant women who attend a series of prepared childbirth classes.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>Proposed data sources include the National Pregnancy and Health Survey, NIH, NICHD; the National Survey of Family Growth (NSFG), CDC, NCHS; and the National Health Interview Survey (NHIS), CDC, NCHS.</p> <p>See Part C for a description of NSFG and NHIS and Appendix A for focus area contact information.</p>
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Obstetrical Care

16-8. Increase the proportion of very low birth weight (VLBW) infants born at level III hospitals or subspecialty perinatal centers.

National Data Source	Title V Reporting System, HRSA, MCHB.
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State Data Source	Title V Reporting System, HRSA, MCHB.
Healthy People 2000 Objective	Adapted from 14.14 (Maternal and Infant Health).
Measure	Percent.
Baseline	73 (1996–97).
Numerator	Number of live births at VLBW in subspecialty facilities (level III facilities).
Denominator	Number of infants born live at VLBW.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	From the Title V Reporting System (Performance Measure 17).
Expected Periodicity	Annual.
Comments	<p>VLBW is defined as a birth weight of less than 1,500 grams (3 lbs 4 ozs).</p> <p>Data are reported by States each year as part of the Maternal and Child Health Block Grant application. A national weighted average is calculated by summing the numerator and denominator information reported by each jurisdiction.</p> <p>This objective differs from Healthy People 2000 objective 14.14, which proposed to track the proportion of VLBW infants born in facilities covered by a neonatologist 24 hours a day. No data are available for Healthy People 2000 objective 14.14.</p> <p>See Appendix A for focus area contact information.</p>



16-9. Reduce cesarean births among low-risk (full-term, singleton, vertex presentation) women.

16-9a. Women giving birth for the first time.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.

Healthy People 2000 Objective	Adapted from 14.8a (Maternal and Infant Health).
Measure	Percent.
Baseline	18 (1998).
Numerator	Number of births delivered by cesarean section to low-risk females giving birth for the first time.
Denominator	Number of live births to low-risk females giving birth for the first time.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>For this objective a low-risk female is defined as one with a full-term (at least 37 weeks since LMP), singleton (not a multiple pregnancy), vertex fetus (head facing in a downward position in the birth canal).</p> <p>A description of the primary measurement used to determine the fetus's gestational age, the interval between the first day of LMP and the birth has been published by NCHS.¹</p> <p>This objective uses a similar calculation protocol as the comparable Healthy People 2000 objective (14.8). The primary differences lie in the data sources used to measure the objective (the Healthy People 2010 objective used data from birth certificates and the Healthy People 2000 objective uses data obtained from hospital records) and the Healthy People 2010 objective focuses on low-risk women, while the Healthy People 2000 objective targeted all women who have not previously delivered an infant by cesarean. A description of how to calculate the Healthy People 2000 cesarean measurement has been published by NCHS.²</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



16-9b. Prior cesarean birth.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Adapted from 14.8b (Maternal and Infant Health).
Measure	Percent.
Baseline	72 (1998).
Numerator	Number of cesarean deliveries to low-risk females who previously delivered an infant by cesarean.
Denominator	Number of live births to low-risk females who previously delivered an infant by cesarean.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>For this objective a low-risk female is defined as one with a full-term (at least 37 weeks since LMP), singleton (not a multiple pregnancy), vertex fetus (head facing in a downward position in the birth canal).</p> <p>A description of the primary measurement used to determine the fetus's gestational age, the interval between the first day of LMP and the birth has been published by NCHS.¹</p>

This objective uses a similar calculation protocol as the comparable Healthy People 2000 objective (14.8). The primary differences lie in the data sources used to measure the objective (the Healthy People 2010 objective uses data from birth certificates and the Healthy People 2000 objective used data obtained from hospital records) and the Healthy People 2010 objective focuses on low-risk women while the Healthy People 2000 objective targets all women who previously delivered an infant by cesarean. A description of how the Healthy People 2000 cesarean measurement was calculated has been published by NCHS.²

This measure is the complement of the vaginal birth after cesarean (VBAC) rate for low-risk women.

See Part C for a description of NVSS and Appendix A for focus area contact information.



Risk Factors

16-10. Reduce low birth weight (LBW) and very low birth weight (VLBW).

16-10a. Low birth weight (LBW).

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	14.5 (Maternal and Infant Health).
Measure	Percent.
Baseline	7.6 (1998).
Numerator	Number of live births with birth weight of less than 2,500 grams (5 lbs 8 oz).
Denominator	Number of live births.
Targeted Population	U.S. resident live births.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



16-10b. Very low birth weight (VLBW).

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	14.5 (Maternal and Infant Health).
Measure	Percent.
Baseline	1.4 (1998).
Numerator	Number of live births with birth weight of less than 1,500 grams (3 lbs 4 oz).
Denominator	Number of live births.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



16-11. Reduce preterm births.

16-11a. Total preterm births.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
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State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	11.6 (1998).
Numerator	Number of infants born prior to 37 completed weeks of gestation.
Denominator	Number of live births.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A description of the primary measurement used to determine the infant's gestational age, the interval between the first day of LMP and the birth has been published by NCHS.¹</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



16-11b. Live births at 32 to 36 weeks of gestation.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	9.6 (1998).
Numerator	Number of infants born between 32 and 36 completed weeks of gestation.
Denominator	Number of live births.
Targeted Population	U.S. resident live births.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A description of the primary measurement used to determine the infant's gestational age—the interval between the first day of LMP and the birth has been published by NCHS.¹</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



16-11c. Live births at less than 32 weeks of gestation.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	2.0 (1998).
Numerator	Number of infants born at less than 32 completed weeks of gestation.
Denominator	Number of live births.
Targeted Population	U.S. resident live births.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A description of the primary measurement used to determine the infant's gestational age—the interval between the first day of LMP and the birth has been published by NCHS.¹</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



16-12. (Developmental) Increase the proportion of mothers who achieve a recommended weight gain during their pregnancies.

Comments

An operational definition could not be provided at the time of publication.

A proposed data source is the 2003 revision of the U.S. Standard Certificate of Live Birth from the National Vital Statistics System (NVSS), CDC, NCHS.

This objective is adapted from Healthy People 2000 objective 14.6, which used data from the 1998 National Maternal and Infant Health Survey. That survey has not been repeated. A description of recommended weight gain for Healthy People 2000 has been published by NCHS.²

See Appendix A for focus area contact information.



16-13. Increase the percentage of healthy full-term infants who are put down to sleep on their backs.

National Data Source	National Infant Sleep Position Study, NIH, NICHD.
State Data Source	Not specified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	35 (1996).
Numerator	Number of infants (less than 8 months) put down to sleep on their backs.
Denominator	Number of infants (less than 8 months).
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	From the 1996 National Infant Sleep Position Study: ➤ <i>There are a number of positions that babies can be put in to sleep. Do you have a position that you usually place the baby in to sleep?</i>

[If Yes:]

*Would that be:
on his/her side,
on his/her stomach with his/her head face down,
on his/her stomach with his/her head turned to the
side,
on his/her back,
or in some other position?*

Expected Periodicity Annual.

Comments Study infants include infants younger than 8 months at time of interview. The total number of infants studied each year was approximately 1,000. An analysis of the National Infant Sleep Position Study has been published elsewhere.⁷

See Appendix A for focus area contact information.



Developmental Disabilities and Neural Tube Defects

16-14. Reduce the occurrence of developmental disabilities.

16-14a. Mental retardation.

National Data Source	Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), CDC, NCEH.
State Data Source	State surveillance systems.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 10,000.
Baseline	131 (1991–94) (metropolitan Atlanta, GA).
Numerator	Number of children aged 8 years with an IQ of 70 or less whose parent(s) or legal guardian(s) reside in metropolitan Atlanta, Georgia.
Denominator	Number of children aged 8 years residing in metropolitan Atlanta, Georgia.
Targeted Population	Resident population (selected areas—see Comments).
Questions Used To Obtain the National Data	Not applicable.

Expected Periodicity	Annual.
Comments	<p>IQ is an acronym for intelligence quotient.</p> <p>If an IQ score was not available, a written statement by a psychometrist that the child's intellectual functioning falls within the range for mental retardation was acceptable.</p> <p>Metropolitan Atlanta, Georgia, consists of a five-county area including Clayton, Cobb, DeKalb, Fulton, and Gwinnett.</p> <p>A description of MADDSP has been published by CDC.⁸</p> <p>See Appendix A for focus area contact information.</p>



16-14b. Cerebral palsy.

National Data Source	Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), CDC, NCEH.
State Data Source	State surveillance systems.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 10,000.
Baseline	32.2 (1991–94) (metropolitan Atlanta, GA).
Numerator	Number of children aged 8 years with cerebral palsy whose parent(s) or legal guardian(s) reside in metropolitan Atlanta, Georgia.
Denominator	Number of children aged 8 years residing in metropolitan Atlanta, Georgia.
Targeted Population	Resident population (selected areas—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	Metropolitan Atlanta, Georgia, consists of a five-county area including Clayton, Cobb, DeKalb, Fulton, and Gwinnett.

A definition of cerebral palsy and a description of MADDSP has been published by CDC.⁸

See Appendix A for focus area contact information.



16-14c. (Developmental) Autism spectrum disorder.

Comments

An operational definition could not be specified at the time of publication.

Data will be available from Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), beginning with 1997 data.

See Appendix A for focus area contact information.



16-14d (Developmental) Epilepsy.

Comments

An operational definition could not be specified at the time of publication.

Data will be available from Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), beginning with 1997 data.

See Appendix A for focus area contact information.



16-15. Reduce the occurrence of spina bifida and other neural tube defects (NTDs).

National Data Source National Birth Defects Prevention Network (NBDPN), CDC, NCEH.

State Data Sources State birth defects monitoring systems; State vital statistics.

Healthy People 2000 Objective Adapted from 14.17 (Maternal and Infant Health).

Measure Ratio per 10,000 live births.

Baseline 6 (1996) (selected States—see Comments).

Numerator	Number of live births and fetal deaths of 20 or more weeks gestation diagnosed with spina bifida and other neural tube defects (ICD-9 codes 740-742.0).
Denominator	Number of live births.
Targeted Population	Resident live births plus fetal deaths (20 or more weeks gestation) (selected States—see Comments).
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A description of the primary measurement used to determine an infant's gestational age—the interval between the first day of LMP and the birth has been published by NCHS.¹</p> <p>NCEH is collaborating with more than 30 States in NBDPN to systematically collect population-based birth defect data in a timely fashion.</p> <p>This objective is comparable to Healthy People 2000 objective 14.17, which was tracked by the Birth Defects Monitoring Program (BDMP) through 1993. However, the BDMP system of voluntary reporting by hospitals was unreliable and no longer exists.</p> <p>See Appendix A for focus area contact information.</p>



16-16. Increase the proportion of pregnancies begun with an optimum folic acid level.

16-16a. Consumption of at least 400 µg of folic acid each day from fortified foods or dietary supplements by nonpregnant women aged 15 to 44 years.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.

Baseline	21 (1991–94).
Numerator	Number of nonpregnant females aged 15 to 44 years who report consuming an average of 400 µg of folic acid daily over the past month.
Denominator	Number of nonpregnant females aged 15 to 44 years.
Targeted Population	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1988–94 National Health and Nutrition Examination Survey: Folic acid intake is estimated from questions regarding vitamin intake for specific vitamin brand names and the frequency and duration of use.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	For this measure only folic acid intake from dietary supplements is included. Folic acid intake from food was not included. In 1991–94, very few women would have been consuming 400 µg folic acid per day unless they were taking a supplement containing folic acid. The method of calculation of this objective involves averaging the intake of folic acid in the past month. Because the number of days in a month varies, the threshold consumption level used in the calculation of the baseline data for this objective is an average of 394 µg per day. See Part C for a description of NHANES and BRFSS and Appendix A for focus area contact information.



16-16b. Median red blood cell (RBC) folate level among nonpregnant women aged 15 to 44 years.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Number (ng/ml).

Baseline	160 (1991–94).
Numerator	Median RBC folate level.
Denominator	Not applicable.
Targeted Population	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual beginning with 1999 data.
Comments	<p>The median RBC folate is a population-weighted estimate from a blood specimen collected from women aged 15 to 44 years as part of the standard NHANES protocol.</p> <p>See Part C for a description of NHANES and Appendix A for focus area contact information.</p>



Prenatal Substance Exposure

16-17 Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.

6-17a. Alcohol.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 14.10 (Maternal and Infant Health).
Measure	Percent.
Baseline	86 (1996–97).
Numerator	Number of nonpregnant females, aged 15 to 44 years, reporting not drinking alcohol at all in the past month (30 days).
Denominator	Number of nonpregnant females aged 15 to 44 years.
Targeted Population	U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data

From the 1996–97 National Household Survey on Drug Abuse:

- *Think about the last time you drank any type of alcoholic beverage. How long has it been since you last drank an alcoholic beverage?*

If you last drank an alcoholic beverage within the past 30 days, mark the first box.

If it has been more than 30 days ago but within the past 12 months that you last drank an alcoholic beverage, mark the second box.

If it was more than 12 months ago but within the past 3 years, mark the third box.

If it has been more than 3 years since you last drank an alcoholic beverage, mark the fourth box.

If you have never drunk an alcoholic beverage in your life, mark the last box.

- *Are you currently pregnant?*

[If yes:]

- *How many months pregnant are you?*
Number of months pregnant _____

Expected Periodicity

Annual.

Comments

To ensure adequate precision of estimates for pregnant women, baseline data are based on combined data from 1996 and 1997 NHSDAs and represent annual average estimates for 1996 and 1997.

This objective is a measure similar to Healthy People 2000 objective 14.10, which used data from the National Maternal and Infant Health Survey and the National Pregnancy and Health Survey.

See Part C for a description of NHSDA and Appendix A for focus area contact information.



16-17b. Binge drinking.

National Data Source

National Household Survey on Drug Abuse (NHSDA), SAMHSA.

State Data Source

Not identified.

Healthy People 2000 Objective

Adapted from 14.10 (Maternal and Infant Health).

Measure

Percent.

Baseline	99 (1996–97).
Numerator	Number of nonpregnant females aged 15 to 44 years reporting not binge drinking at all in the past month (30 days).
Denominator	Number of nonpregnant females aged 15 to 44 years.
Targeted Population	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1996–97 National Household Survey on Drug Abuse:</p> <p>➤ <i>During the past 30 days, on how many days did you have 5 or more drinks on the same occasion? By “occasion,” we mean at the same time or within a couple of hours of each other.</i> <i>On the solid line, write the number of days in the past 30 days when you drank 5 or more drinks of an alcoholic beverage on the same occasion.</i></p> <p><i>If you never had 5 or more drinks on the same occasion on any day when you drank during the past 30 days, mark the first box.</i></p> <p><i>If you have never drunk an alcoholic beverage in your life, mark the last box.</i></p> <p>➤ <i>Are you currently pregnant?</i></p> <p>[If yes:]</p> <p>○ <i>How many months pregnant are you?</i> <i>Number of months pregnant _____</i></p>
Expected Periodicity	Annual.
Comments	<p>Binge drinking is defined as drinking five or more alcoholic drinks on the same occasion on at least one day in the past 30 days. By “occasion” is meant at the same time or within a couple of hours of each other.</p> <p>To ensure adequate precision of estimates for pregnant women, baseline data are based on combined data from 1996 and 1997 NHSDAs and represent annual average estimates for 1996 and 1997.</p>

This objective is adapted from Healthy People 2000 objective 14.10, which measured use of alcohol during pregnancy data from the National Maternal and Infant Health Survey and the National Pregnancy and Health Survey. Binge drinking during pregnancy was not addressed in Healthy People 2000.

See Part C for a description of NHSDA and Appendix A for focus area contact information.



16-17c. Cigarette smoking.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	14.10 (Maternal and Infant Health).
Measure	Percent.
Baseline	87 (1998) (selected areas—see Comments).
Numerator	Number of women having live births reporting abstaining from cigarette smoking during pregnancy.
Denominator	Number of live births.
Targeted Population	Resident population (selected areas—see Comments).
Questions Used To Obtain the National Data	<p>From the U.S. Standard Certificate of Live Birth (1989 revision):</p> <p>➤ <i>Other risk factors for this pregnancy - Complete all items.</i> [A number of check boxes are provided including...] Tobacco use during pregnancy..... yes <input type="checkbox"/> no <input type="checkbox"/> Average number of cigarettes per day _____</p>
Expected Periodicity	Annual.
Comments	Baseline data for smoking during pregnancy are for 46 States, the District of Columbia, and New York City. Data on smoking during pregnancy were not available for California, Indiana, New York State (New York City did report), and South Dakota.

See Part C for a description of NVSS and Appendix A for focus area contact information.



16-17d. Illicit drugs.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 14.10 (Maternal and Infant Health).
Measure	Percent.
Baseline	98 (1996–97).
Numerator	Number of nonpregnant females aged 15 to 44 years reporting not using any illicit drugs in the past month (30 days).
Denominator	Number of nonpregnant females aged 15 to 44 years who were pregnant.
Targeted Population	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1996–97 National Household Survey on Drug Abuse:</p> <p>[The following question is asked separately for each illicit drug: marijuana or hashish, cocaine, “crack,” heroin, hallucinogens, and inhalants:]</p> <p>➤ <i>How long has it been since you last used [marijuana or hashish, cocaine, “crack,” heroin, hallucinogens, inhalants]?</i></p> <p><i>If your answer is within the past 30 days, mark the first box.</i></p> <p><i>If your answer is more than 30 days ago but within the past 12 months, mark the second box.</i></p> <p><i>If your answer is more than 12 months ago but within the past 3 years, mark the third box.</i></p> <p><i>If your answer is more than 3 years ago, mark the next-to-last box.</i></p> <p><i>If you have never used (marijuana or hashish, cocaine, “crack,” heroin, hallucinogens, inhalants) in your life, mark the last box.</i></p>

[The following questions are asked separately for nonmedical use of analgesics (prescription pain killers), tranquilizers, stimulants, and sedatives:]

- *As you read the following list of (prescription pain killers, tranquilizers, stimulants, sedatives), please mark one box beside each (pain killer, tranquilizers, stimulants, sedatives) to indicate whether you have ever used that (pain killer, tranquilizers, stimulants, sedatives) when it was not prescribed for you, or that you took only for the experience or feeling it caused. Again, we are interested in all kinds of (prescription pain killers, tranquilizers, stimulants, sedatives), in pill or nonpill form.*

[This question is followed by a list of common drugs in the category specified and the following additional questions:]

- *Have you ever used a (pain killer, tranquilizers, stimulants, sedatives) whose name you don't know that was not prescribed for you, or that you took only for the experience or feeling it caused? If "YES," mark the first box; if "NO," mark the second box.*
- *Have you ever used any other (pain killer, tranquilizers, stimulants, sedatives) besides the ones listed above, that was not prescribed for you, or that you took only for the experience or feeling it caused? PLEASE PRINT NAME(S) OF OTHER [PAIN KILLERS, TRANQUILIZERS, STIMULANTS, SEDATIVES] BELOW. If "YES," mark the first box; if "NO," mark the second box.*

[If the respondent reported use of any (pain killer, tranquilizers, stimulants, sedatives) they are asked:]

- *How long has it been since you last used (a pain killer, tranquilizers, stimulants, sedatives) that was not prescribed for you, or that you took only for the experience or feeling it caused?
If your answer is within the past 30 days, mark the first box.
If your answer is more than 30 days ago but within the past 12 months, mark the second box.
If your answer is more than 12 months ago but within the past 3 years, mark the third box.
If your answer is more than 3 years ago, mark the next-to-last box.*

- *Are you currently pregnant?*

[If "yes":]

- *How many months pregnant are you?
Number of months pregnant _____*

Expected Periodicity Annual.

Comments

Illicit drugs are defined as marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP and LSD), heroin, and nonmedical use of psychotherapeutics.

To ensure adequate precision of estimates for pregnant women, baseline data are based on combined data from 1996 and 1997 NHSDAs and represent annual average estimates for 1996 and 1997.

This objective is adapted from Healthy People 2000 objective 14.10, which tracked abstinence from marijuana and cocaine use during pregnancy with data from the National Maternal and Infant Health Survey and the National Pregnancy and Health Survey. The Healthy People 2010 objective measures abstinence from any illicit drug.

See Part C for a description of NHSDS and Appendix A for focus area contact information.



16-18. (Developmental) Reduce the occurrence of fetal alcohol syndrome (FAS).

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the Fetal Alcohol Syndrome Network (FASNet), CDC.

This objective is comparable to Healthy People 2000 objective 14.4, which was tracked by the Birth Defects Monitoring Program (BDMP) through 1993. However, the BDMP system of voluntary reporting by hospitals was unreliable and no longer exists.

See Appendix A for focus area contact information.



Breastfeeding, Newborn Screening, and Service Systems

16-19. Increase the proportion of mothers who breastfeed their babies.

16-19a. In early postpartum period.

National Data Source	Mothers' Survey, Ross Products Division, Abbott Laboratories, Inc.
State Data Source	Not identified.
Healthy People 2000 Objective	14.9 (Maternal and Infant Health) (also 2.11).
Measure	Percent.
Baseline	64 (1998).
Numerator	Number of mothers who indicate that breast milk is at least one of the types of milk their infant was fed in the hospital.
Denominator	Number of mothers of infants aged 1 to 12 months.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	<p>From the 1998 Mothers' Survey:</p> <p>➤ <i>Please check the milks your youngest baby was fed in the hospital:</i> <i>Breast milk</i> <i>(List of formulas)</i> <i>Cow's milk</i></p>
Expected Periodicity	Annual.
Comments	<p>Early postpartum breastfeeding is defined as breastfeeding a newborn infant before being discharged from the hospital.</p> <p>Surveys are sent out monthly to a sample of mothers with infants of every month of age between 1 month and 12 months. All are asked about the milk their infants were fed in the hospital, so the entire sample forms the denominator for this objective.</p> <p>Respondents can check more than one type of milk. If breast milk is checked, the mother is considered to be breastfeeding, regardless of whether other milk or formulas are used.</p>

A description of the Mothers' Survey has been published elsewhere.⁹

See Appendix A for focus area contact information.



16-19b. At 6 months.

National Data Source	Mothers' Survey, Ross Products Division, Abbott Laboratories, Inc.
State Data Source	Not identified.
Healthy People 2000 Objective	14.9 (Maternal and Infant Health) (also 2.11).
Measure	Percent.
Baseline	29 (1998).
Numerator	Number of mothers who indicate that breast milk is at least one of the types of milk their infant was fed 6 months after delivery.
Denominator	Number of mothers of infants aged 6 months.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	<p>From the 1998 Mothers' Survey:</p> <p>➤ <i>Please check the milks your youngest baby was fed most often in the last week:</i> <i>Breast milk</i> <i>(List of formulas)</i> <i>Cow's milk</i></p>
Expected Periodicity	Annual.
Comments	<p>Surveys are sent out monthly to a sample of mothers with infants of every month of age between 1 month and 12 months.</p> <p>Respondents can check more than one type of milk. If breast milk is checked, the mother is considered to be breastfeeding, regardless of whether other milk or formulas are used as well.</p> <p>A description of the Mothers' Survey has been published elsewhere.⁹</p> <p>See Appendix A for focus area contact information.</p>

16-19c. At 1 year.

National Data Source	Mothers' Survey, Ross Products Division, Abbott Laboratories, Inc.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 14.9 (Maternal and Infant Health) (also 2.11).
Measure	Percent.
Baseline	16 (1998).
Numerator	Number of mothers who indicate that breast milk is at least one of the types of milk their infant was fed 1 year after delivery.
Denominator	Number of mothers of infants aged 1 year.
Targeted Population	U.S. resident population.
Questions Used To Obtain the National Data	<p>From the 1998 Mothers' Survey:</p> <p>➤ <i>Please check the milks your youngest baby was fed most often in the last week:</i> <i>Breast milk</i> <i>(List of formulas)</i> <i>Cow's milk</i></p>
Expected Periodicity	Annual.
Comments	<p>Surveys are sent out monthly to a sample of mothers with infants of every month of age between 1 month and 12 months.</p> <p>Respondents can check more than one type of milk. If breast milk is checked, the mother is considered to be breastfeeding, regardless of whether other milk or formulas are used as well.</p> <p>A description of the Mothers' Survey has been published elsewhere.⁹</p> <p>This objective is comparable to Healthy People 2000 objective 14.9; however, the measurement of infants aged 1 year is new to Healthy People 2010.</p> <p>See Appendix A for focus area contact information.</p>



16-20. (Developmental) Ensure appropriate newborn bloodspot screening, followup testing, and referral to services.

16-20a. Ensure that all newborns are screened at birth for conditions mandated by their State-sponsored newborn screening programs, for example, phenylketonuria and hemoglobinopathies.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Title V Performance Measures, HRSA, MCHB and the National Newborn Screening and Genetic Resource Center.

This objective is adapted from Healthy People 2000 objective 14.15, which measured newborns screened by State-sponsored programs for genetic disorders and referral for appropriate treatment. Healthy People 2000 objective 14.15 was tracked with data from the Council of Regional Networks for Genetic Services, Association of State and Territorial Public Health Laboratory Directors.

See Appendix A for focus area contact information.



16-20b. Ensure that followup diagnostic testing for screening positives is performed within an appropriate time period.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Title V Performance Measures, HRSA, MCHB, and the National Newborn Screening and Genetic Resource Center.

This objective is adapted from Healthy People 2000 objective 14.15, which measured newborns screened by State-sponsored programs for genetic disorders and referral for appropriate treatment. Healthy People 2000 objective 14.15 was tracked with data from the Council of Regional Networks for Genetic Services, Association of State and Territorial Public Health Laboratory Directors.

See Appendix A for focus area contact information.

16-20c. Ensure that infants with diagnosed disorders are enrolled in appropriate service interventions within an appropriate time period.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Title V Performance Measures, HRSA, MCHB, and the National Newborn Screening and Genetic Resource Center.

This objective is Healthy People 2000 objective 14.15, which measured newborns screened by State-sponsored programs for genetic disorders and referral for appropriate treatment. Healthy People 2000 objective 14.15 was tracked with data from the Council of Regional Networks for Genetic Services, Association of State and Territorial Public Health Laboratory Directors.

See Appendix A for focus area contact information.



16-21. (Developmental) Reduce hospitalization for life-threatening sepsis among children aged 4 years and under with sickling hemoglobinopathies.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the National Hospital Discharge Survey (NHDS), CDC, NCHS.

See Part C for a description of NHDS and Appendix A for focus area contact information.



16-22. (Developmental) Increase the proportion of children with special health care needs who have access to a medical home.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the Title V Reporting System, HRSA, MCHB.

See Appendix A for focus area contact information.



16-23. Increase the proportion of Territories and States that have service systems for children with special health care needs.

National Data Source	Title V Block Grant Application Form 13, HRSA, MCHB.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 17.20 (Diabetes and Other Chronic Disabling Conditions).
Measure	Percent.
Baseline	15.7 (1997)
Numerator	Number of States and Territories that have a score of at least 10 (of a possible 12) on a four-part rating of aspects of a coordinated continuum of appropriate services for children with special health care needs (CSHCN).
Denominator	59 States and Territories.
Questions Used To Obtain the National Data	<p>From the Title V Block Grant Application (Form 13), in which State Title V officials are asked to rate their programs on the following criteria:</p> <ul style="list-style-type: none">• <i>State program collaboration with other State agencies and private organizations. The State has established and maintained an ongoing interagency collaborative process for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.</i>

- *State support for communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.*
- *Coordination of health components of community-based systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.*
- *Coordination of health services with other services at the community level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.*

Expected Periodicity Annual.

Comments Possible responses to each are 0 (not met), 1 (partially met), 2 (mostly met), and 3 (completely met). The State's score is the sum of the four ratings.

This objective is adapted from Healthy People 2000 objective 17.20, which tracked the number of States that had service systems for children with or at risk of chronic disabling conditions, as required by Public Law 101-239. A data source was never identified to track Healthy People 2000 objective 17.20.

See Appendix A for focus area contact information.



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17

Medical Product Safety

- 17-1 Monitoring of adverse medical events
 - 17-1a Medical therapies
 - 17-1b Medical devices
- 17-2 Linked, automated information systems
 - 17-2a Hospitals and comprehensive, integrated health care systems
 - 17-2b Pharmacists and other dispensers
- 17-3 Provider review of medications taken by patients
- 17-4 Receipt of useful information about prescriptions from pharmacies
- 17-5 Receipt of oral counseling about medications from prescribers and dispensers
 - 17-5a Prescribers
 - 17-5b Pharmacists
- 17-6 Blood donations

17-1. (Developmental) Increase the proportion of health care organizations that are linked in an integrated system that monitors and reports adverse events.

17-1a. (Developmental) Health care organizations that are linked in an integrated system that monitors and reports adverse events associated with medical therapies.

Comments

An operational definition could not be specified at the time of publication.

Proposed national data sources are the Office of Postmarketing Drug Risk Assessment (OPDRA), MedWatch, and Manufacturer and User Device Experience (MAUDE) Database, FDA.

An adverse event is an undesirable result from use of a medical product. This includes terms such as adverse drug reaction (ADR), adverse experiment, and adverse effect.

See Appendix A for focus area contact information.



17-1b. (Developmental) Health care organizations that are linked in an integrated system that monitors and reports adverse events associated with medical devices.

Comments

An operational definition could not be specified at the time of publication.

Proposed national data sources are the Office of Postmarketing Drug Risk Assessment (OPDRA), MedWatch, and Manufacturer and User Device Experience (MAUDE) Database, FDA.

An adverse event is an undesirable result from use of a medical product. This includes terms such as adverse drug reaction (ADR), adverse experiment, and adverse effect.

A medical device is an instrument, apparatus, implement, implant, machine, or other similar or related article intended in use for the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease.

See Appendix A for focus area contact information.



17-2. (Developmental) Increase the use of linked, automated systems to share information.

17-2a. (Developmental) By health care professionals in hospitals and comprehensive, integrated health care systems.

Comments

An operational definition could not be specified at the time of publication.

Proposed national data sources are the National Survey of Pharmacy Practice in Acute Care and Survey of Managed Care and Ambulatory Care Pharmacy Practice in Integrated Health Systems, American Society of Hospital Pharmacists (ASHP).

See Appendix A for focus area contact information.



17-2b. (Developmental) By pharmacists and other dispensers.

Comments

An operational definition could not be specified at the time of publication.

Proposed national data sources are the National Survey of Pharmacy Practice in Acute Care and Survey of Managed Care and Ambulatory Care Pharmacy Practice in Integrated Health Systems, American Society of Hospital Pharmacists (ASHP).

See Appendix A for focus area contact information.



17-3. (Developmental) Increase the proportion of primary care providers, pharmacists, and other health care professionals who routinely review with their patients aged 65 years and older and patients with chronic illnesses or disabilities all new prescribed and over-the-counter medicines.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Survey on Prescription Drug Issues and Usage, AARP; and the Physician Survey under the Medication Error Reduction Initiative.

This objective is adapted from a measure in Healthy People 2000 objective 12.6 (Food and Drug Safety), which tracked the proportion of primary care physicians who routinely review with their patients aged 65 years and older all prescriptions and over-the-counter medicines taken by their patients each time a new medication is prescribed.

This measure tracks the proportion of primary care physicians, pharmacists, and other health care professionals who routinely review with their patients aged 65 years and older, as well as patients with chronic illnesses or disabilities all new prescribed and over-the-counter medicines.

See Appendix A for focus area contact information.



17-4. (Developmental) Increase the proportion of patients receiving information that meets guidelines for usefulness when their new prescriptions are dispensed.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the Patient/Consumer Medication Information Survey, FDA.

This objective is adapted from a measure in Healthy People 2000 objective 12.8 (Food and Drug Safety), which tracked the proportion of people who receive useful information verbally and in writing for new prescriptions from prescribers or dispensers. This measure tracks the proportion of patients receiving information that meets guidelines for usefulness when new prescriptions are dispensed.

See Appendix A for focus area contact information.



17-5. Increase the proportion of patients who receive verbal counseling from prescribers and pharmacists on the appropriate use and potential risks of medications.

17-5a. Prescribers

Comments

A complete operational definition was not provided at the time of publication.

The national data source is the National Survey of Prescription Drug Information Provided to Patients, FDA.

This objective is adapted from a measure in Healthy People 2000 objective 12.8 (Food and Drug Safety), which tracked the proportion of people who receive useful information verbally and in writing for new prescriptions from prescribers or dispensers. This measure tracks the proportion of patients receiving verbal counseling from prescribers only on appropriate use and potential risk of medications.

See Appendix A for focus area contact information.



17-5b. Pharmacists

Comments

A complete operational definition was not provided at the time of publication.

The national data source is the National Pharmacy Consumer Survey, American Pharmaceutical Association.

This objective is adapted from a measure in Healthy People 2000 objective 12.8 (Food and Drug Safety), which tracked the proportion of people who receive useful information verbally and in writing for new prescriptions from prescribers or dispensers. This measure tracks the proportion of patients receiving verbal counseling from pharmacists only on appropriate use and potential risk of medications.

See Appendix A for focus area contact information.



17-6. Increase the proportion of persons who donate blood, and in so doing ensure an adequate supply of safe blood.

Comments

A complete operational definition was not provided at the time of publication.

The national data source is the American Association of Blood Banks.

See Appendix A for focus area contact information.



18

Mental Health and Mental Disorders

Mental Health Status Improvement

- 18-1 Suicide
- 18-2 Adolescent suicide attempts
- 18-3 Serious mental illness (SMI) among homeless adults
- 18-4 Employment of persons with SMI
- 18-5 Eating disorder relapses

Treatment Expansion

- 18-6 Primary care screening and assessment
- 18-7 Treatment for children with mental health problems
- 18-8 Juvenile justice facility screening
- 18-9 Treatment for adults with mental disorders
 - 18-9a Adults aged 18 to 54 years with serious mental illness
 - 18-9b Adults aged 18 years and older with recognized depression
 - 18-9c Adults aged 18 years and older with schizophrenia
 - 18-9d Adults aged 18 years and older with generalized anxiety disorder
- 18-10 Treatment for co-occurring disorders
- 18-11 Adult jail diversion programs

State Activities

- 18-12 State tracking of consumer satisfaction
- 18-13 State plans addressing cultural competence
- 18-14 State plans addressing elderly persons

Mental Health Status Improvement

18-1. Reduce the suicide rate.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	6.1 (Mental Health and Mental Disorders) (also 7.2), age adjusted to 2000 standard population.
Measure	Rate per 100,000 (age adjusted, see Comments).
Baseline	11.3 (1998).
Numerator	Number of deaths due to suicide (ICD-9 codes E950-E959).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Suicides may be undercounted because of difficulty in the determination of suicidal intent by coroner or medical examiner.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 6.1, which was age adjusted to the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



18-2. Reduce the rate of suicide attempts by adolescents.

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	7.8 (Violent and Abusive Behavior) (also 6.2).
Measure	Percent.
Baseline	2.6 (1999).
Numerator	Number of students in grades 9 through 12 who reported suicide attempts that required medical attention in the 12 months preceding the survey.
Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	<p>From the 1999 Youth Risk Behavior Survey:</p> <p>➤ <i>If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning or overdose that had to be treated by a doctor or a nurse?</i></p> <p>1) <i>I did not attempt suicide during the past 12 months</i> 2) <i>Yes</i> 3) <i>No</i></p>
Expected Periodicity	Biennial.
Comments	See Part C for a description of YRBSS and Appendix A for focus area contact information.



18-3. Reduce the proportion of homeless adults who have serious mental illness (SMI).

National Data Source	Projects for Assistance in Transition from Homelessness (PATH) Annual Application, SAMHSA, CMHS.
State Data Source	Projects for Assistance in Transition from Homelessness (PATH) Annual Application, SAMHSA, CMHS.

Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	25 (1996).
Numerator	Sum of State estimates of the number of people aged 18 years and older who have a serious mental illness and are homeless.
Denominator	Sum of State estimates of the number of people aged 18 years and older who are homeless.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The Federal definition of serious mental illness (SMI) specifies that the mental condition interfered with the person's ability to work or find work. State definitions of SMI may vary. States provide estimates of the number of homeless persons and the number of homeless persons with SMI in their annual PATH grant applications. The procedures used to estimate the numbers of homeless people and homeless people with SMI vary considerably across States.</p> <p>See Appendix A for focus area contact information.</p>



18-4. Increase the proportion of persons with serious mental illness (SMI) who are employed.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	43 (1994).

Numerator	Number of persons aged 18 years and older who report having either a serious mental illness; having Diagnostic Interview Schedule (DIS) or Composite International Diagnostic Interview (CIDI) symptoms; or having used prescription medicine for mental disorders in the past 12 months, and who also report that the symptoms “seriously interfere” with work, school, or day-to-day activities, and report being employed in the past 12 months.
Denominator	Number of persons aged 18 years and older who report having either a serious mental illness; having Diagnostic Interview Schedule (DIS) or Composite International Diagnostic Interview (CIDI) symptoms; or having used prescription medicine for mental disorders in the past 12 months, and who also report that the symptoms “seriously interfere” with work, school, or day-to-day activities.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1994 National Health Interview Survey:

[NUMERATOR:]

- *During the past 12 months was (Names) employed?*

[DENOMINATOR:]

- *During the past 12 months did (Name of persons 18 years and older) have –*
Schizophrenia?
Paranoid or delusional disorder other than schizophrenia?
Manic episodes or manic depression, also called bipolar disorder?
Major depression? (Major depression is a depressed mood and loss of interest in almost all activities for at least 2 weeks)
Anti-social personality, obsessive compulsive personality or any severe personality disorder?
Alzheimer’s disease or another type of senile disorder?
- *Are (Names) FREQUENTLY depressed or anxious?*
- *Do (Names) have a lot of trouble making or keeping friendships?*
- *Do (Names) have a lot of trouble getting along with other people in social or recreational settings?*
- *Do (Names) have a lot of trouble concentrating long enough to complete everyday tasks?*

- *Do (Names) have **SERIOUS** difficulty coping with day-to-day stresses?*
- *Are (Names) **FREQUENTLY** confused, disoriented or forgetful?*
- *Do (Names) have phobias or **UNREASONABLY** strong fears, that is, a fear of something or some situation where most people would not be afraid?*
- *During the past 12 months, did any of these problems **SERIOUSLY** interfere with ability to work or attend school or to manage day-to-day activities?*

Expected Periodicity

Periodic.

Comments

Persons are considered to have a serious mental illness if they respond “yes” to any of the questions designated as DENOMINATOR questions above.

The baseline for this objective came from the disability supplement to the 1994 NHIS; there are currently no plans to repeat this supplement, so an alternative source will have to be identified for updates.

See Part C for a description of NHIS and Appendix A for focus area contact information.



18-5. (Developmental) Reduce the relapse rates for persons with eating disorders, including anorexia nervosa and bulimia nervosa.

Comments

An operational definition could not be specified at the time of publication. The proposed national data source is the Prospective Studies of Patients with Anorexia or Bulimia Nervosa, NIH, NIMH.

See Appendix A for focus area contact information.



Treatment Expansion

18-6. (Developmental) Increase the number of persons seen in primary health care who receive mental health screening and assessment.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the Primary Care Data System/Federally Qualified Health Centers, HRSA.

See Appendix A for focus area contact information.



18-7. (Developmental) Increase the proportion of children with mental health problems who receive treatment.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the National Household Survey on Drug Abuse (NHSDA), SAMHSA.

See Appendix A for focus area contact information.



18-8. (Developmental) Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the Inventory of Mental Health Services in Juvenile Justice Facilities, SAMHSA.

See Appendix A for focus area contact information.



18-9. Increase the proportion of adults with mental disorders who receive treatment.

18-9a. Adults aged 18 to 54 years with serious mental illness.

National Data Source	National Comorbidity Survey (NCS), SAMHSA, CMHS; NIH, NIMH.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	47 (1991).
Numerator	Number of adults aged 18 to 54 years who report symptoms of serious mental illness and that they received help from a mental health professional.
Denominator	Number of adults aged 18 to 54 years who report symptoms of serious mental illness.
Population Targeted	U.S. civilian, noninstitutionalized coterminous population.
Questions Used To Obtain the National Data	See Comments.
Expected Periodicity	Periodic.
Comments	The National Comorbidity Survey (NCS) used a modified version of the Composite International Diagnostic Interview (CIDI) to collect data for this objective.

The SMI definition required at least one DSM-III-R disorder other than substance use disorders in the past 12 months and serious impairment. Severe mental illness is defined as: 1) a diagnosis of schizophrenia, schizoaffective disorder, manic depressive disorder, autism, severe forms of major depression, panic disorder, and obsessive compulsive disorder; 2) 12-month prevalence of nonaffective psychosis or mania; 3) lifetime prevalence of nonaffective psychosis or mania; or 1-2-month prevalence of either major depression or panic disorder with evidence of severity. The SMI definition included those with a 12-month mental disorder that interfered with their vocational capacity, their main productive role, or was associated with serious interpersonal impairment.

See Appendix A for focus area contact information.



18-9b. Adults aged 18 years and older with recognized depression.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
Healthy People 2000 Objective	Adapted from 6.7 (Mental Health and Mental Disorders).
Leading Health Indicator	Mental Health.
Measure	Percent.
Baseline	23 (1997).
Numerator	Number of adults aged 18 years and older who report symptoms of depression and that they received help from a mental health professional.
Denominator	Number of adults aged 18 years and older who report symptoms of depression.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997 National Household Survey of Drug Abuse:

[NUMERATOR:]

- *During the past 12 months, how many different times have you stayed overnight or longer in a hospital to receive treatment for psychological or emotional difficulties?*
- *Have you received treatment for psychological problems or emotional difficulties at a mental health clinic or by a mental health professional on an outpatient basis in the past 12 months?*

[DENOMINATOR:]

- *During the past 12 months, was there ever a time when you felt sad, blue, or depressed for 2 weeks or more in a row?*

For the next few questions, please think of the 2-week period when these feelings were worst.

- *During that time, did the feeling of being sad, blue, or depressed usually last:*
 - All day long?*
 - Most of the day?*
 - About half the day?*
 - Less than half the day?*
- *Did you feel this way:*
 - Every day?*
 - Almost every day?*
 - Less often?*
- *During those 2 weeks, did you lose interest in most things?*
- *Did you feel tired or low on energy all of the time?*
- *Did you gain weight, lose weight or stayed about the same?*
 - Gained weight?*
 - Lost weight?*
 - Both gained and lost weight*
 - Stayed the same*
- *About how much weight did you gain/lose?*
- *Did you have more trouble falling asleep than you usually do?*
- *Did that happen every night, nearly every night or less often during those 2 weeks?*
 - Every night?*
 - Nearly every night?*
 - Less often?*
- *Did you have a lot more trouble concentrating than usual?*

- *At these times, people sometimes feel down on themselves, no good or worthless. Did you feel this way?*
- *Did you think a lot about death—either your own, someone else's, or death in general?*

Expected Periodicity

Annual.

Comments

This objective differs from Healthy People 2000 objective 6.7 in that it uses a different age group and data source; objective 6.7 limited the data to persons aged 18 to 54 years and used data from the ECA and NCS.

This objective is one of the measures used to track the Mental Health Leading Health Indicator. See Appendix H for a complete listing.

See Part C for a discussion of NHSDA and Appendix A for focus area contact information.



18-9c. Adults aged 18 years and older with schizophrenia.

National Data Source

Epidemiologic Catchment Area (ECA) Program, NIH, NIMH.

State Data Source

Not identified.

Healthy People 2000 Objective

Not applicable.

Measure

Percent.

Baseline

60 (1984).

Numerator

Adults aged 18 years and older who were diagnosed with schizophrenia and who received treatment.

Denominator

Adults 18 years and older who were diagnosed with schizophrenia.

Population Targeted

U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data

See Comments.

Expected Periodicity

Periodic.

Comments

The Epidemiologic Catchment Area (ECA), NIMH, NIH study provided the baseline for this objective; there are currently no plans to repeat this 1984 study.

The ECA used the Diagnostic Interview Schedule (DIS) to collect the data. The data are limited to: 1) persons who were diagnosed with DSM-III-R schizophrenia within the last year or, 2) persons who were diagnosed with DSM-III-R schizophrenia at some other point during their life with evidence of severity, including use within the past year of any inpatient psychiatric hospitalization or nursing home placement; any outpatient mental health treatment in a specialty mental health or general medical setting; or psychotic symptoms. Treatment questions included use of inpatient or ambulatory service sectors in the last 12 months.

See Appendix A for focus area contact information.

**18-9d. Adults aged 18 years and older with generalized anxiety disorder.**

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	38 (1997).
Numerator	Number of adults aged 18 years and older who report symptoms of anxiety disorders and that they received help from a mental health professional.
Denominator	Number of adults aged 18 years and older who report symptoms of anxiety disorders.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997 National Household Survey on Drug Abuse:

[NUMERATOR:]

- *During the past 12 months, how many different times have you stayed overnight or longer in a hospital to receive treatment for psychological or emotional difficulties?*
- *Have you received treatment for psychological problems or emotional difficulties at a mental health clinic or by a mental health professional on an outpatient basis in the past 12 months?*

[DENOMINATOR:]

- *During the past 12 months, did you ever have a period lasting 1 month or longer when most of the time you felt worried or anxious?*

[If yes:]

- *Has that period ended or is it still going on?*
 - Ended*
 - Still going on*
 - *How many months or years did it go on before it ended?*
- *During that period, did you worry about things that were not likely to happen?*
 - *Did you worry a great deal about things that were not really serious?*
 - *During this period of worry or anxiety, did you have different worries that were on your mind at the same time?*
 - *How many years or months has it been going on?*
 - *Do you worry about things that are not likely to happen?*
 - *Do you worry a great deal about things that are not really serious?*
 - *Do you have different worries on your mind at the same time?*
 - *When you (are/were) worried or anxious (are/were) you also—*
 - Restless?*
 - Keyed up or on edge?*
 - Particularly irritable?*
 - Aware of your heart pounding or racing?*
 - Easily tired?*
 - Have trouble falling asleep or staying asleep?*
 - Feel faint or unreal?*

Expected Periodicity

Annual.

Comments

See Part C for a description of NHSDA and Appendix A for focus area contact information.



18-10. (Developmental) Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

Comments

An operational definition could not be specified at the time of publication.

Proposed national data sources are the National Health Interview Survey (NHIS), CDC, NCHS; the National Household Survey on Drug Abuse (NHSDA), SAMHSA; or the Replication of National Comorbidity Survey, NIH, NIMH.

See Appendix A for focus area contact information.



18-11. (Developmental) Increase the proportion of local governments with community-based jail diversion programs for adults with serious mental illness (SMI).

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the National Survey of Jail Mental Health Diversion Programs, SAMHSA.

See Appendix A for focus area contact information.



State Activities

18-12. Increase the number of States and the District of Columbia that track consumers' satisfaction with the mental health services they receive.

National Data Source

Mental Health Statistics Improvement Program (MHSIP), SAMHSA, CMHS.

State Data Source	Mental Health Statistics Improvement Program (MHSIP), SAMHSA, CMHS.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	36 (1999).
Numerator	Number of States and the District of Columbia that report to MHSIP results of a consumer satisfaction survey.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Appendix A for focus area contact information.



18-13. (Developmental) Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses cultural competence.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>The proposed national data source is the National Technical Assistance Center for State Mental Health Systems, SAMHSA.</p> <p>See Appendix A for focus area contact information.</p>
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18-14. Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses mental health crisis interventions, ongoing screening, and treatment services for elderly persons.

National Data Source	National Technical Assistance Center for State Mental Health Systems, SAMHSA, CMHS.
State Data Source	National Technical Assistance Center for State Mental Health Systems, SAMHSA, CMHS.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	24 (1997).
Numerator	Number of States and the District of Columbia that report an operational mental health plan that addresses mental health crisis interventions, ongoing screening, and treatment services for elderly persons.
Denominator	Not applicable.
Questions Used To Obtain the National Data	<p>From the 1998 National Association of State Mental Health Program Directors' survey:</p> <p>➤ <i>Does the Mental Health system operate a separate, specialized treatment unit/program for elderly clients?</i></p>
Expected Periodicity	Annual.
Comments	<p>Data for Territories are currently unavailable.</p> <p>See Appendix A for focus area contact information.</p>



19

Nutrition and Overweight

Weight Status and Growth

- 19-1 Healthy weight in adults
- 19-2 Obesity in adults
- 19-3 Overweight or obesity in children and adolescents
 - 19-3a Aged 6 to 11 years
 - 19-3b Aged 12 to 19 years
 - 19-3c Aged 6 to 19 years
- 19-4 Growth retardation in children

Food and Nutrient Consumption

- 19-5 Fruit intake
- 19-6 Vegetable intake
- 19-7 Grain product intake
- 19-8 Saturated fat intake
- 19-9 Total fat intake
- 19-10 Sodium intake
- 19-11 Calcium intake

Iron Deficiency and Anemia

- 19-12 Iron deficiency in young children and in females of childbearing age
 - 19-12a Children aged 1 to 2 years
 - 19-12b Children aged 3 to 4 years
 - 19-12c Nonpregnant females aged 12 to 49 years
- 19-13 Anemia in low-income pregnant females
- 19-14 Iron deficiency in pregnant females

Schools, Worksites, and Nutrition Counseling

- 19-15 Meals and snacks at school
- 19-16 Worksite promotion of nutrition education and weight management
- 19-17 Nutrition counseling for medical conditions

Food Security

- 19-18 Food security

Weight Status and Growth

19-1. Increase the proportion of adults who are at a healthy weight.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP. (See Comments.)
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	42 (1988–94).
Numerator	Number of persons aged 20 years and older with a BMI equal to or greater than 18.5 and less than 25.0.
Denominator	Number of persons in the survey population aged 20 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>The NHANES obtains measured weights and heights without shoes. BMI is calculated by dividing weight in kilograms by the square of height in meters.</p> <p>The selection of a BMI cut-point to establish the healthy weight range is based on the relationship of overweight or obesity to disease or death. A BMI of less than 25 has been accepted by numerous groups as the upper limit of the healthy weight range, because more disease occurs in most populations at or above this cut-point.^{1, 2, 3, 4} The lower cut-point for the healthy weight range (BMI of 18.5) was selected to be consistent with national and international recommendations.^{1, 3, 4}</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.</p>

State-level data on self-reported heights and weights are collected annually in BRFSS for adults aged 18 years and older. This data source enables States to estimate the proportion of the population that reports heights and weights in the healthy range and to track trends, although the method of measurement (through telephone interview) differs from the national measures. Body weight prevalence estimates derived from self-reported heights and weights tend to be lower than those derived from measured height and weight.

See Part C for a description of NHANES and Appendix A for focus area contact information.



19-2. Reduce the proportion of adults who are obese.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP. (See Comments.)
Healthy People 2000 Objective	Adapted from 2.3 (Nutrition) (also 1.2, 15.10, 17.12).
Leading Health Indicator	Overweight and Obesity.
Measure	Percent (age adjusted—see Comments).
Baseline	23 (1988–94).
Numerator	Number of persons aged 20 years and older with a BMI at or above 30.0.
Denominator	Number of persons in the survey population aged 20 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	NHANES obtains measured weights and heights without shoes. BMI is calculated by dividing weight in kilograms by the square of height in meters.

BMI will be used as a proxy for overweight and obesity in adults until a better measure of body fat is developed. In 1997, a Consultation on Obesity convened by the World Health Organization recommended standardizing the classification of overweight and obesity.⁵ Overweight was defined as a BMI of 25.0 or greater and obesity was defined as a BMI of 30.0 or greater. Further classification of obesity was made as follows: 30.0-34.9 was defined as Class I obesity, 35.0-39.9 as Class II, and 40.0 or greater as Class III.

The Expert Panel on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, convened by NIH, recently adopted general concepts of the World Health Organization classification system^{1, 5} and it has now been endorsed by more than 50 professional medical societies, consumer groups, and government agencies. For this objective, therefore, a BMI cutoff point of 30.0 was chosen for adults aged 20 years and older. Since 1960, essentially all of the increased prevalence of overweight and obesity in adults in the United States has occurred at a BMI greater than or equal to 30.0.^{1, 5, 6}

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

State-level data on self-reported heights and weights are collected annually in BRFSS for adults, but are not comparable to the national statistics. These data enable States to estimate the proportion of the population that reports heights and weights in the obese range and to track trends, although the method of measurement (through telephone interview) differs from the national measures. Body weight prevalence estimates derived from self-reported heights and weights tend to be lower than those derived from measured height and weight.

This objective differs from Healthy People 2000 objective 2.3 (Nutrition), which defined overweight as a BMI greater than or equal to 27.8 for men and 27.3 for women. The values used for Healthy People 2000 corresponded with the gender-specific 85th percentile of the 1976–80 NHANES II reference population 20 to 29 years of age and were not age adjusted.

This objective is one of the measures used to track the Overweight and Obesity Leading Health Indicator. See Appendix H for a complete list.

See Part C for a description of NHANES and Appendix A for focus area contact information.



19-3. Reduce the proportion of children and adolescents who are overweight or obese.

19-3a. Children aged 6 to 11 years.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.3 (Nutrition) (also 1.2, 15.10, 17.12).
Measure	Percent.
Baseline	11 (1988–94).
Numerator	Number of children aged 6 to 11 years with a BMI at or above the gender- and age-specific 95th percentile from the CDC Growth Charts: United States.
Denominator	Number of children in the survey population aged 6 to 11 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.

Comments

The NHANES obtains measured weights and heights without shoes. BMI is calculated by dividing weight in kilograms by the square of height in meters.

BMI will be used as a proxy for overweight and obesity in children and adolescents until a better measure is developed.⁷ There is a prepubertal increase in subcutaneous fat that is lost during adolescence in boys, while in girls fat deposition continues. There also is a differential increase in muscle (or lean body mass) by gender during puberty. Thus, without measures of sexual maturity, measures of body fat and body weight are equally difficult to interpret in preadolescents and adolescents.

In 2000, the 1977 NCHS Growth Charts were revised to consider additional large, nationally representative samples of children aged 2 to 20 years from the 1976–80 NHANES and the 1988–94 NHANES and to provide BMI for age in lieu of weight for age.⁸ When extrapolated to age 20 years, the gender- and age-specific 95th percentile of BMI from the Revised CDC Growth Charts approximates a BMI of 30. Thus, the 95th percentiles of BMI for children aged 6 to 11 years and for adolescents aged 12 to 19 years were chosen to estimate the prevalence of overweight and obesity for this objective. The CDC Growth Charts can be found on the Internet at <http://www.cdc.gov/growthcharts>.

In addition to the revised measure, this objective differs from Healthy People 2000 objective 2.3, which did not track overweight in children aged 6 to 11 years.

See Part C for a description of NHANES and Appendix A for focus area contact information.



19-3b. Adolescents aged 12 to 19 years.

National Data Source National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

State Data Source Not identified.

Healthy People 2000 Objective	Adapted from 2.3 (Nutrition) (also 1.2, 15.10, 17.12).
Measure	Percent.
Baseline	11 (1988–94).
Numerator	Number of adolescents aged 12 to 19 years with a BMI at or above the gender- and age-specific 95th percentile from the CDC Growth Charts: United States.
Denominator	Number of adolescents in the survey population aged 12 to 19 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>State-level data on self-reported heights and weights are collected biennially in the Youth Risk Behavior Surveillance System (YRBSS) for adolescents in grades 9 through 12. This data source enables States to estimate the proportion of this population that reports heights and weights in the overweight and obese ranges and to track trends, although the methods of measurement differ from the national measure. Body weight prevalence estimates derived from self-reported heights and weights tend to be lower than those derived from measured height and weight.</p> <p>See Comments provided with objective 19-3a for more information on the methods of calculation.</p> <p>This objective differs from Healthy People 2000 objective 2.3, which defined overweight for adolescents based on modified age- and gender-specific 85th percentile values of the 1976–80 NHANES II. For adolescents, overweight was defined as a BMI equal to or greater than 23.0 for males aged 12 to 14 years, 24.3 for males aged 15 to 17 years, 25.8 for males aged 18 to 19 years, 23.4 for females aged 12 to 14 years, 24.8 for females aged 15 to 17 years, and 25.7 for females aged 18 to 19 years.</p>

See Part C for a description of NHANES and
Appendix A for focus area contact information.



19-3c. Children and adolescents aged 6 to 19 years.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.3 (Nutrition) (also 1.2, 15.10, 17.12).
Leading Health Indicator	Overweight and Obesity.
Measure	Percent.
Baseline	11 (1988–94).
Numerator	Number of children and adolescents aged 6 to 19 years with a BMI at or above the gender- and age-specific 95th percentile from the CDC Growth Charts: United States.
Denominator	Number of children and adolescents in the survey population aged 6 to 19 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	See Comments provided with objective 19-3a for more information on methods of calculation and see objective 19-3b for more information on State-level data.

This objective differs from Healthy People 2000 objective 2.3, which defined overweight for adolescents based on modified age- and gender-specific 85th percentile values of the 1976–80 NHANES II. For adolescents, overweight was defined as a BMI equal to or greater than 23.0 for males aged 12 to 14 years, 24.3 for males aged 15 to 17 years, 25.8 for males aged 18 to 19 years, 23.4 for females aged 12 to 14 years, 24.8 for females aged 15 to 17 years, and 25.7 for females aged 18 to 19 years.

This objective is one of the measures used to track the Overweight and Obesity Leading Health Indicator. See Appendix H for a complete list.

See Part C for a description of NHANES and Appendix A for focus area contact information.



19-4. Reduce growth retardation among low-income children under age 5 years.

National Data Source	Pediatric Nutrition Surveillance System (PedNSS), CDC, NCCDPHP.
State Data Source	Pediatric Nutrition Surveillance System (PedNSS), CDC, NCCDPHP.
Healthy People 2000 Objective	2.4 (Nutrition).
Measure	Percent.
Baseline	8 (1997) (preliminary) (selected sites—see Comments).
Numerator	Number of low-income children under age 5 years who are below the 5th percentile of height for age.
Denominator	Number of low-income children under age 5 years.
Population Targeted	Selected sites—see Comments.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

For the preliminary baseline estimates, growth retardation is defined as height for age below the 5th percentile in the age-gender-appropriate reference population using the 1977 NCHS Growth Charts (that is, data from the Fels Research Institute and the 1971–74 NHANES).⁹

The 1997 baseline estimates were obtained from PedNSS, which collects annual data from participating States on growth retardation among low-income children. These data are collected from low-income, high-risk infants and children who participate in publicly funded health, nutrition, and food assistance programs such as WIC; the Early Periodic Screening, Diagnosis, and Treatment program; and clinics funded by Maternal and Child Health Program Block Grants.

In 1997, 44 States, the District of Columbia, and five Tribal governments provided data for tracking growth retardation nationally. Data can also be analyzed at clinic, county, and State levels. Estimates from PedNSS are not based on a nationally representative sample. Participation in publicly funded programs in a State can vary from year to year and can be affected by fluctuating resources. Further, the number of participating States and Tribal governments in PedNSS has varied from year to year. The fluctuations in the scope of surveillance can affect the representation and comparability of estimates.

The final national estimates used to track this objective will differ from Healthy People 2000 objective 2.4 because they will be based on the revised CDC Growth Charts and not the 1977 NCHS Growth Charts.

See Appendix A for focus area contact information.



Food and Nutrient Consumption

Objectives 19-5 to 19-11 address the proportion of the population that consumes specified levels of foods (fruit, vegetables, grain products) and nutrients (fat, sodium, and calcium), based on the recommendations of the 2000 *Dietary Guidelines for Americans*.⁴ Recommendations for food and nutrient intake are not intended to be met every day, but rather on average over a span of time. However, the national surveys used to track these objectives have, in recent years, collected no more than 2 days of dietary data. Accordingly, the baseline estimates for these dietary intake objectives reflect either 2-day averages or the use of statistical adjustment procedures to estimate usual intake for population groups. It is also important to track and report mean intakes by different population groups. Estimates of mean intakes provide a measure of central tendency that is not conveyed by the proportion meeting the objective and tend to be more stable. Optimally, tracking data should also include an assessment of trends with regard to at-home versus away-from-home eating.

For the food intake objectives, the 1994–96 CSFII was chosen to provide baseline estimates because it contained the most recent national survey data available for intake estimates that account for the contribution of foods used as ingredients in mixtures. This survey was also chosen to provide baseline estimates for the fat and saturated fat intake objectives because it provided the most recent national estimates. In contrast, the 1988–94 NHANES was chosen to provide baseline estimates for the sodium and calcium objectives because it provides total nutrient intake estimates that account for the contribution of dietary supplements as well as other nonfood sources of these nutrients.

In the early 2000s, the dietary components of CSFII and NHANES will be merged into one National Food and Nutrition Survey (NFNS). This survey will be used to provide update estimates for all of the food and nutrient consumption objectives, with the potential for annual updates for larger population segments and multiyear updates for smaller segments.

19-5. Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.

National Data Source	Continuing Survey of Food Intakes by Individuals (CSFII), USDA, ARS.
State Data Sources	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP and Youth Risk Factor Surveillance System (YRBSS), CDC, NCCDPDP. (See Comments.)
Healthy People 2000 Objective	Adapted from 2.6 (Nutrition) (also 16.8).

Measure	Percent (age adjusted—see Comments).
Baseline	28 (1994–96).
Numerator	Number of persons aged 2 years and older who report consuming two or more servings of fruit daily (based on a 2-day average).
Denominator	Number of persons in the survey population aged 2 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1994–96 Continuing Survey of Food Intakes by Individuals:</p> <p>The 1994–96 CSFII included the collection of 2 nonconsecutive days of dietary data through in-person 24-hour recalls.¹⁰ Each respondent was asked to recall the kinds and amounts of foods eaten at home and away from home during the previous day. Amounts of foods reported in household measures were then converted to gram amounts.</p>
Expected Periodicity	Annual.
Comments	<p>The definitions for fruit and for serving sizes were derived from the 1995 Dietary Guidelines,¹¹ the Food Guide Pyramid (http://www.usda.gov/cnpp/pyramid2.htm), and related documentation, and estimates were calculated using the USDA Pyramid Servings Database. The intakes of fruit servings were modified for children aged 2 to 3 years. The modification was accomplished by multiplying their daily servings intake by 1.5, equivalent to estimating that their requirement is two-thirds that of persons over age 3 years. Fruit ingredients from mixtures are included in the total, and fractions of servings are counted.¹²</p> <p>Pregnant or lactating women and breast-fed children are excluded from the numerator and denominator.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.</p>

State-level data on fruit and vegetable consumption are collected biennially by BRFSS for persons 18 years and older and YRBSS for adolescents in grades 9 through 12. No State-level data for younger children are available from these surveillance systems. These data enable States to track (1) the proportion of the population that consumes five or more servings of fruits and vegetables daily, (2) mean intakes and trends in consumption, and (3) consumption of selected fruit and vegetable items. However, the food items and dietary data collection methods used in these surveillance systems differ from those used by CSFII to track Healthy People 2010 objective 19-5.

This objective differs from Healthy People 2000 objective 2.6, which only tracked the proportion of the population that consumed five or more daily servings of fruits and vegetables and the mean number of servings consumed, with a few exclusions of fruit and vegetable products. Also, Healthy People 2000 estimates were not age adjusted.

See Part C for a description of CSFII and Appendix A for focus area contact information.



19-6. Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third of them being dark green or orange vegetables.

National Data Source	Continuing Survey of Food Intakes by Individuals (CSFII), USDA, ARS.
State Data Sources	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP and Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP. (See Comments.)
Healthy People 2000 Objective	Adapted from 2.6 (Nutrition) (also 16.8).
Measure	Percent (age adjusted—see Comments).
Baseline	3 (1994–96).

Numerator	Number of persons who report consuming three or more servings of vegetables daily, of which at least one-third are dark green or orange vegetables (based on a 2-day average).
Denominator	Number of persons in the survey population aged 2 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 19-5.
Expected Periodicity	Annual.
Comments	<p>The definitions for dark green and orange vegetables and for serving sizes were derived from the 1995 Dietary Guidelines (http://www.health.gov/dietaryguidelines),¹¹ the Food Guide Pyramid (http://www.usda.gov/cnpp/pyramid2.htm), and related documentation, and estimates were calculated using the USDA Pyramid Servings Database. The goal of one-third of servings from dark green or orange vegetables was based on an assessment of the variety of vegetable consumption needed to obtain nutrient adequacy in the development of the Food Guide Pyramid. The intakes of vegetable servings were modified for children aged 2 to 3 years. The modification was accomplished by multiplying their daily servings intake by 1.5, equivalent to estimating that their requirement is two-thirds that of persons over age 3 years. Vegetable ingredients from mixtures are included in the total, and fractions of servings are counted.¹²</p> <p>Pregnant or lactating women and breast-fed children are excluded from the numerator and denominator.</p> <p>Two component measures will also be tracked: (1) age-adjusted percent of persons that report consuming three or more servings of vegetables daily (based on a 2-day average), and (2) age-adjusted percent of persons that report consuming at least one-third of their vegetables as dark green or orange vegetables (based on a 2-day average).</p>

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

State-level data on fruit and vegetable consumption are collected biennially by BRFSS for persons 18 years and older and YRBSS for adolescents in grades 9 through 12. No State-level data for younger children are available from these surveillance systems. These data enable States to track (1) the proportion of the population that consumes five or more servings of fruits and vegetables daily, (2) mean intakes and trends in consumption, and (3) consumption of selected fruit and vegetable items. However, the food items and dietary data collection methods used in these surveillance systems differ from those used by CSFII to track Healthy People 2010 objective 19-6.

The objective differs from Healthy People 2000 objective 2.6, which tracked only the proportion of the population that consumed five or more servings daily of fruits and vegetables and the mean number of servings consumed, with a few exclusions of fruit and vegetable products. Also, Healthy People 2000 estimates were not age adjusted.

See Part C for a description of CSFII and Appendix A for focus area contact information.



19-7. Increase the proportion of persons aged 2 years and older who consume at least six daily servings of grain products, with at least three being whole grains.

National Data Source	Continuing Survey of Food Intakes by Individuals (CSFII), USDA, ARS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.6 (Nutrition) (also 16.8).
Measure	Percent (age adjusted—see Comments).
Baseline	7 (1994–96).

Numerator	Number of persons aged 2 years and older who report consuming six or more servings of grain products per day, including three or more servings of whole-grain products (based on 2-day average).
Denominator	Number of persons in the survey population aged 2 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 19-5.
Expected Periodicity	Annual.
Comments	<p>The definitions for grain products and for serving sizes were derived from the 1995 Dietary Guidelines (http://www.health.gov/dietaryguidelines),¹¹ the Food Guide Pyramid (http://www.usda.gov/cnpp/pyramid2.htm), and related documentation. Estimates were calculated using the USDA Pyramid Servings Database, which provided data on total and whole grain consumption.^{12, 13}</p> <p>The goal of three servings from whole-grain products was based on an assessment of the variety of grain product consumption needed to obtain nutrient adequacy in the development of the Food Guide Pyramid. The intakes of grain servings were modified for children aged 2 to 3 years. The modification was accomplished by multiplying their daily servings intake by 1.5, equivalent to estimating that their requirement is two-thirds that of persons over age 3 years. Grain ingredients from mixtures are included in the total, and fractions of servings are counted.</p> <p>Pregnant or lactating women and breast-fed children are excluded from the numerator and denominator.</p> <p>Two component measures will also be tracked: (1) age-adjusted percent of persons who consumed six or more servings of grain products per day (based on 2-day average), and (2) age-adjusted percent of persons who consumed three or more servings of whole-grain products (based on 2-day average).</p>

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

This objective differs from Healthy People 2000 objective 2.6, which tracked the proportion of the population who consumed six or more servings of grain products daily and the mean number of servings consumed, with no exclusions. Also, Healthy People 2000 estimates were not age adjusted.

See Part C for a description of CSFII and Appendix A for focus area contact information.



19-8. Increase the proportion of persons aged 2 years and older who consume less than 10 percent of calories from saturated fat.

National Data Source	Continuing Survey of Food Intakes by Individuals (CSFII), USDA, ARS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.5 (Nutrition) (also 15.9 and 16.7).
Measure	Percent (age adjusted—see Comments).
Baseline	36 (1994–96).
Numerator	Number of persons aged 2 years and older who report consuming less than 10.0 percent of calories from saturated fat (based on 2-day average).
Denominator	Number of persons in the survey population aged 2 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1994–96 Continuing Survey of Food Intakes by Individuals:

CSFII included the collection of 2 nonconsecutive days of dietary data through in-person 24-hour recalls.¹⁰ Each respondent was asked to recall the kinds of amounts of foods eaten at home and away from home during the previous day. Amounts of foods reported in household measures were then converted to gram amounts, and saturated fat intake estimated with the use of food composition files.

Expected Periodicity	Annual.
Comments	<p>This objective tracks the proportion of the population that meets recommendations for saturated fat consumption in the 2000 Dietary Guidelines for Americans.⁴ Additional tracking of saturated fat intake expressed in grams may also help in interpreting how much progress has been made, since a decrease in saturated fat intake as a percentage of calories may not reflect a decrease in grams of saturated fat if, for example, carbohydrate intake has increased.</p> <p>Pregnant or lactating women and breast-fed children are excluded from the numerator and denominator.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 2.5, which tracked the proportion of the population who consumed less than 10 percent of calories from saturated fat, as well as the mean saturated fat intake of population groups; the tracking data were not age adjusted.</p> <p>See Part C for a description of CSFII and Appendix A for focus area contact information.</p>



19-9. Increase the proportion of persons aged 2 years and older who consume no more than 30 percent of calories from total fat.

National Data Source	Continuing Survey of Food Intakes by Individuals (CSFII), USDA, ARS.
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State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.5 (Nutrition) (also 15.9 and 16.7).
Measure	Percent (age adjusted—see Comments).
Baseline	33 (1994–96).
Numerator	Number of persons aged 2 years and older who report consuming less than or equal to 30 percent of calories from total fat (based on 2-day average).
Denominator	Number of persons in the survey population aged 2 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 19-8.
Expected Periodicity	Annual.
Comments	<p>This objective tracks the proportion of the population that meets recommendations for total fat consumption in the 2000 Dietary Guidelines for Americans.⁴ Additional tracking of fat intake expressed in grams may also help in interpreting how much progress has been made, because a decrease in fat intake as a percent of calories may not reflect a decrease in grams of fat if, for example, carbohydrate intake has increased.</p> <p>Pregnant or lactating women and breast-fed children are excluded from the numerator and denominator.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 2.5, which tracked the mean fat intake of population groups and the proportion of the population who consumed 30 percent or fewer calories from fat; the tracking data were not age adjusted.</p> <p>See Part C for a description of CSFII and Appendix A for focus area contact information.</p>



19-10. Increase the proportion of persons aged 2 years and older who consume 2,400 mg or less of sodium daily.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.9 (Nutrition).
Measure	Percent (age adjusted—see Comments).
Baseline	21 (1988–94).
Numerator	Number of persons aged 2 years and older who report consuming less than or equal to 2,400 mg of sodium daily.
Denominator	Number of persons in the survey population aged 2 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1988–94 National Health and Nutrition Examination Survey:</p> <p>Foods:</p> <p>NHANES included the collection of 1 day of dietary data for all respondents through in-person 24-hour recalls¹⁴ and 2-day dietary data on a small subset through telephone 24-hour recalls. Each respondent was asked to recall the kinds and amounts of foods and beverages consumed at home and away from home during the previous day (midnight to midnight). Amounts of foods and beverages reported in household measures were then converted to gram amounts, and sodium intake from foods and beverages estimated with the use of food composition files. Additional questions used to assess total sodium intake include:</p> <p>Dietary supplement use:</p> <ul style="list-style-type: none">➤ <i>Has (Person) taken any vitamins or minerals in the past month? Please include those that are prescribed by a doctor or dentist and those that are not prescribed.</i>➤ <i>Has (Person) taken or used any medicines for which a doctor's or dentist's prescription is needed, in the past month? This includes any products which cannot be obtained without a doctor's or dentist's prescription. Include those medicines you may have already mentioned.</i>

[If yes:]

- *May I see the containers for all of the (vitamins and minerals/prescription medicines) (Person) took in the past month?*

Enter complete name of vitamin/mineral from label, or probe respondent.

Container seen

Container not seen

Product furnished by respondent

Product name not on container

Enter manufacturer's or distributor's name and address (city and State)

- *How often did (Person) take (product) in the past month?*
- *How much (product) did (Person) take each time (Person) took it?*

Number of capsules, tablet/pills; teaspoons; tablespoons; fluid ounces/ounces; drops/droppers; packets/packs/packages; ml.; wafers; other.

- *For how long has (Person) been taking this type of product?*

Tap water:

- *How much plain drinking water do you usually drink in a 24-hour period? Include only plain tap or spring water.*

Number of glasses or cups

Number of ounces per glass or cup

- *Does your home drinking water have a water softening or conditioning system?*

Salt use at the table:

- *What type of salt (do you/does Person) usually add to (your/his/her) food at the table?*

None

Ordinary salt

Lite salt

Salt substitute

- *How often (do you/does Person) add (type of salt) to (your/his/her) food at the table? Is it rarely, occasionally, or very often?*

Expected Periodicity

Comments

Annual, beginning with 1999 data.

The baseline estimates include consideration of several sources of sodium intake: foods, dietary supplements, tap water, and salt use at the table but do not include sodium intake from antacids and other medications. In addition, a statistical procedure was

used to remove the within-person variation in daily sodium intakes from food,¹⁵ and thus provide better estimates of usual intake of sodium with the use of dietary data per individual (that is, 1 day of dietary data for all NHANES respondents and 2-day dietary data for a subset).

It is possible that update estimates for certain population segments may be available annually for this objective, whereas estimates for smaller subgroups will require multiyear data.

Regarding salt use at table, sea salt, flavored salts such as garlic, onion, and celery salt, and seasoning salts were counted as ordinary salts. Lite salt was labeled as such and has a reduced sodium content. Salt substitutes do not contain sodium. To obtain a daily amount for each person, the amount of sodium depending on salt type was multiplied by the frequency value. (Sodium in type of salt x frequency amount of sodium from table salt added per day.)

Type of salt: A zero sodium value was assigned for “none” and “salt substitute.” For “ordinary salt,” 290 mg (for “very often” code) was assigned for persons aged 2 to 19 years, and 580 mg was assigned for persons aged 20 years and older. For “lite” salt, 145 mg was assigned for persons aged 2 to 19 years, and 290 mg was assigned for persons aged 20 years and older. For missing values, a default of “ordinary salt” was assigned.

Frequency of salt use: for “rarely,” sodium value was multiplied by 1/4; for “occasionally,” sodium value was multiplied by 1/2; for “very often,” sodium value was multiplied by 1; for missing values, “occasionally” was used as the default.

Drinking water: If home drinking water had a water softening or conditioning system, ounces of water consumed were multiplied by 3 mg per fluid ounce; otherwise, water was counted as unsoftened; 1 mg per fluid ounce was used for “regular” municipal water based on the USDA food composition database. To get daily sodium from drinking water, the mg of sodium per fluid ounce was multiplied by the number of fluid ounces.

Dietary supplements: Sodium from dietary supplements reported in the survey was calculated. If supplement data were missing, then it was assumed

that no sodium was provided by supplements but the individual was kept in the calculation.

Breast-feeding children aged 2 years and older were excluded from the analysis.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

This objective differs from Healthy People 2000 objective 2.9, which also tracked individual behaviors associated with the reduction of salt and sodium intake. The measures included avoidance of salt use in food preparation at home, avoidance of salt use at the table, and regular purchase of foods modified in sodium, but did not measure actual sodium intake. The Healthy People 2000 tracking data were not age adjusted.

See Part C for a description of NHANES and Appendix A for focus area contact information.



19-11. Increase the proportion of persons aged 2 years and older who meet dietary recommendations for calcium.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.8 (Nutrition).
Measure	Percent (age adjusted—see Comments).
Baseline	46 (1988–94).
Numerator	Number of persons aged 2 years and older who report calcium intake at or above approximated mean requirements.
Denominator	Number of persons in the survey population aged 2 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1988–94 National Health and Nutrition Examination Survey:

Foods:

The NHANES included the collection of 1 day of dietary data for all respondents through in-person 24-hour recalls and 2-day dietary data on a small subset through telephone 24-hour recalls. Each respondent was asked to recall the kinds and amounts of foods and beverages consumed at home and away from home during the previous day (midnight to midnight). Amounts of foods and beverages reported in household measures were then converted to gram amounts, and calcium intake from foods and beverages was estimated with the use of food composition files. Additional questions used to assess total calcium intake include:

[Dietary supplement use:]

- *Has (Person) taken any vitamins or minerals in the past month? Please include those that are prescribed by a doctor or dentist and those that are not prescribed.*
- *Has (Person) taken or used any medicines for which a doctor's or dentist's prescription is needed, in the past month? This includes any products which cannot be obtained without a doctor's or dentist's prescription. Include those medicines you may have already mentioned.*

[If yes:]

- *May I see the containers for all of the (vitamins and minerals/prescription medicines) (Person) took in the past month?*

Enter complete name of vitamin/mineral from label, or probe respondent.

Container seen

Container not seen

Product furnished by respondent

Product name not on container

[Enter manufacturer's or distributor's name and address (city and State)]

- *How often did (Person) take (product) in the past month?*
- *How much (product) did (Person) take each time (Person) took it?*
Number of capsules, tablet/pills; teaspoons; tablespoons; fluid ounces/ounces; drops/droppers; packets/packs/packages; ml.; wafers; other.
- *For how long has (Person) been taking this type of product?*

[Antacid use:]

Enter complete name of antacid from label or probe respondent:

Antacid seen

Antacid not seen. Product name furnished by respondent

- *How often did you take (antacid) in the past month?*
- *How much (antacid) did you take each time you took it?*
- *For how long have you been taking this antacid?*

Expected Periodicity

Annual, beginning with 1999 data.

Comments

Approximated mean calcium requirements are defined as 77 percent of the recommendations by the Institute of Medicine for adequate intakes for calcium.^{16, 17} The prepublication recommendations for adequate intakes of calcium are 500 mg per day for children aged 1 to 3 years, 800 mg for children aged 4 to 8 years, 1,300 mg for adolescents aged 9 to 18 years, 1,000 mg for adults aged 19 to 50 years, and 1,200 mg for adults aged 51 years and older.¹⁷

Persons were classified as consuming calcium at or above the approximated mean requirements if the total daily calcium intake was within this range. To determine total calcium intake, several sources of calcium were considered, including foods, dietary supplements, and antacids, but not including calcium from drinking water.

A statistical procedure was used to remove the within-person variation in daily calcium intakes from food¹⁵ and thus provide better estimates of usual intake of calcium with the use of a limited number of days of dietary data per individual (1 day of dietary data for all NHANES respondents and 2-day dietary data for a subset).

Calcium from calcium-containing antacids reported as taken 24 times or more was used in the calculation. If antacids data were missing, it was assumed that no calcium was provided by antacids, but the individual was kept in the calculation.

Breast-feeding children aged 2 years and older were excluded from the analysis.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

State-level data on self-reported consumption of milk are collected biennially by the Youth Risk Behavioral Surveillance System (YRBSS), for adolescents in grades 9 through 12.

This objective differs from Healthy People 2000 objective 2.8, which only tracked the proportion of the population who consumed the recommended number of servings of milk and milk products; the 2000 objective did not consider calcium intake from other foods, dietary supplements, and antacids. Given that significant sources of calcium are not limited to milk products and not all persons choose to consume them, the Healthy People 2010 objective aims to increase total calcium intake. However, because consumption of milk products is low relative to recommendations for adolescents and other groups who would especially benefit from increased consumption of calcium-rich foods, it is still often desirable to track milk product consumption at the national and State levels as supplementary data, as well as to track the contribution of other sources of total calcium intake. The Healthy People 2000 tracking data were not age adjusted.

See Part C for a description of NHANES and Appendix A for focus area contact information.



Iron Deficiency and Anemia

19-12. Reduce iron deficiency among young children and females of childbearing age.

19-12a. Children aged 1 to 2 years.

National Data Source National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

State Data Source Not identified (see Comments).

Healthy People 2000 Objective	Adapted from 2.10 (Nutrition).
Measure	Percent.
Baseline	9 (1988–94).
Numerator	Number of children aged 1 to 2 years with abnormal results for two or more of the following tests: serum ferritin, free erythrocyte protoporphyrin, or transferrin saturation. ^{18, 19}
Denominator	Number of children in the survey population aged 1 to 2 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	Blood was collected by phlebotomy. Transferrin saturation was calculated by dividing serum iron by total iron binding capacity. Serum iron and total iron binding capacity were measured colorimetrically (by Alpkem RFA analyzer, Clackamas, OR), and 1 percent thiourea was added to complex copper to prevent copper interference. ²⁰ Free erythrocyte protoporphyrin was measured via fluorescence extraction, ²¹ and serum ferritin was measured with the BioRad Quantimmune IRMA kit (BioRad Laboratories, Hercules, CA).

Iron deficiency is defined as abnormal results for two or more of the following tests: serum ferritin, free erythrocyte protoporphyrin, or transferrin saturation. The basis of the use for two of three abnormal tests was the finding that populations with only one abnormal test of these three had scarcely more anemia than those with all normal test results. The prevalence of anemia was substantially elevated in those who had two or three abnormal tests.^{19, 22} The selection of threshold values for abnormal results were based on those derived for the previous NHANES (1976–80) by an expert panel,^{19, 23} except where (1) evidence existed for changes in assay methods or in changes in other confounding factors like blood lead; and (2) an evaluation of the iron status indicator distribution in a reference group of healthy persons from the 1988–94 NHANES supported a change in the 1976–80 NHANES thresholds.¹⁸

Threshold values for abnormal results on iron tests vary by age. Abnormal values for serum ferritin concentration are defined as less than 10 µg/L for children aged 1 to 4 years and less than 12 µg/L for females aged 12 to 49 years. Abnormal values for free erythrocyte protoporphyrin are greater than 1.42 µmol/L for children aged 1 to 2 years (80 µg/dL of red blood cells), and greater than 1.24 µmol/L (70 µg/dL of red blood cells) for other persons. Abnormal values for transferrin saturation are less than 10 percent for children aged 1 to 2 years, less than 12 percent for children aged 3 to 4 years, less than 14 percent for females aged 12 to 15 years, and less than 15 percent for females aged 16 years and older.

The terms anemia, iron deficiency, and iron deficiency anemia are often used interchangeably, but are not equivalent. Anemia can be caused by many factors other than iron deficiency, including other nutrient deficiencies, infection, inflammation, and hereditary anemias. When the prevalence of iron deficiency is high, such as during the third trimester of pregnancy, anemia is a good predictor of iron deficiency. When the prevalence of iron deficiency is low, such as among white, non-Hispanic children aged 3 to 4 years in the United States, the majority of anemia is due to other causes.

No comparable data source is available to measure iron deficiency at the State level. The Pediatric Nutrition Surveillance System is used to monitor the percent of anemia (low hemoglobin or hematocrit) among low-income children aged 1 to 4 years participating in public health programs.

Anemia is used for monitoring risk of iron deficiency at the State and local levels because of its cost and feasibility for use in the clinic setting. Changes in the prevalence of anemia over time at the State and local levels can be used to evaluate the effectiveness of programs to decrease the prevalence iron deficiency.

This objective differs from Healthy People 2000 objective 2.10, which defined iron deficiency as abnormal results for two or more of the following tests: mean cell volume, free erythrocyte protoporphyrin, and transferrin saturation. For Healthy People 2010 objective 19-12, serum ferritin replaces mean cell volume in the definition of iron deficiency. Serum ferritin is a more sensitive measure of iron deficiency.²⁴

See Part C for a description of NHANES and Appendix A for focus area contact information.



19-12b. Children aged 3 to 4 years.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified (see Comments).
Healthy People 2000 Objective	Adapted from 2.10 (Nutrition).
Measure	Percent.
Baseline	4 (1988–94).
Numerator	Number of children aged 3 to 4 years with abnormal results for two or more of the following tests: serum ferritin, free erythrocyte protoporphyrin, or transferrin saturation. ^{18, 19}

Denominator	Number of children in the survey population aged 3 to 4 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	See Comments provided with objective 19-12a for more information on the measurement of this objective. See Part C for a description of NHANES and Appendix A for focus area contact information.



19-12c. Nonpregnant females aged 12 to 49 years.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.10 (Nutrition).
Measure	Percent.
Baseline	11 (1988–94).
Numerator	Number of females aged 12 to 49 years with abnormal results for two or more of the following tests: serum ferritin, free erythrocyte protoporphyrin, or transferrin saturation. ^{18, 19}
Denominator	Number of females in the survey population aged 12 to 49 years.
Population Targeted	U.S. civilian noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	See Comments provided with objective 19-12a for more information on the measurement of this objective.

See Part C for a description of NHANES and Appendix A for focus area contact information.



19-13. Reduce anemia among low-income pregnant females in their third trimester.

National Data Source	Pregnancy Nutrition Surveillance System (PNSS), CDC, NCCDPHP.
State Data Source	State Pregnancy Nutrition Surveillance System (PNSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 2.10e (Nutrition).
Measure	Percent.
Baseline	29 (1996) (Selected sites—see Comments).
Numerator	Number of pregnant females participating in public programs in their third trimester with abnormal results for either hemoglobin (less than 11 g/dL) or hematocrit (less than 33 percent). ²⁵
Denominator	Number of pregnant females participating in public programs in their third trimester.
Population Targeted	Selected sites—see Comments.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	PNSS is used to monitor anemia among low-income women participating in public health programs. In 1996, 21 States, the District of Columbia, and two Tribal governments participated. ^{25, 26} The threshold for anemia during pregnancy is based on clinical studies of European women who had taken iron supplementation during pregnancy. ^{27, 28, 29, 30, 31} This threshold is advocated by CDC ²⁵ and the World Health Organization. ³²

See the Comments section with iron deficiency objective 19-12 for a discussion of the differences between iron deficiency and anemia. Nationally representative data are unavailable for monitoring the percent of iron deficiency during pregnancy.

This objective differs from Healthy People 2000 objective 2.10e, which targeted black, low-income pregnant females only.

See Appendix A for focus area contact information.



19-14. (Developmental) Reduce iron deficiency among pregnant females.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health and Nutrition Examination Survey (NHANES).

See Appendix A for focus area contact information.



Schools, Worksites, and Nutrition Counseling

19-15. (Developmental) Increase the proportion of children and adolescents aged 6 to 19 years whose intake of meals and snacks at school contributes to good overall dietary quality.

Comments

An operational definition could not be specified at the time of publication.

Proposed national data sources are the Continuing Survey of Food Intakes by Individuals (CSFII), USDA, ARS; the National Food and Nutrition Survey, USDA, ARS and CDC, NCHS; or the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS. A proposed State data source for adolescents (students in grades 9 through 12) is the Youth Risk Behavior Surveillance System (YRBSS).

This objective is adapted from Healthy People 2000 objective 2.17, which tracked the proportion of schools offering breakfasts and lunches with 30 percent or less of calories from total fat, the proportion of schools offering breakfasts and lunches with less than 10 percent of calories from saturated fat, and the proportion of schools with initiatives to reduce fat.

See Appendix A for focus area contact information.



19-16. Increase the proportion of worksites that offer nutrition or weight management classes or counseling.

National Data Source	1999 National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP) and OPHS, ODPHP.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.20 (Nutrition).
Measure	Percent.
Baseline	55 (1998–99).
Numerator	Number of worksites with 50 or more employees that offered nutrition or weight management classes or counseling at the worksite or through their health plans.
Denominator	Number of worksites with 50 or more employees in nongovernmental organizations.
Questions Used To Obtain the National Data	<p>From the 1999 National Worksite Health Promotion Survey:</p> <ul style="list-style-type: none"> ➤ <i>During the last 12 months, did you offer [see below] to your employees at the worksite?</i> <ul style="list-style-type: none"> 1) <i>Nutrition or cholesterol education</i> 2) <i>Weight management classes or counseling</i> ➤ <i>During the last 12 months, did you offer [see below] to your employees through one of your health plans?</i> <ul style="list-style-type: none"> 1) <i>Nutrition or cholesterol education</i> 2) <i>Weight management classes or counseling</i>
Expected Periodicity	Periodic.

Comments

Responses to the two questions on nutrition or cholesterol education and weight management classes or counseling are combined for tracking this objective.³³

This objective differs from Healthy People 2000 objective 2.20, which was tracked with three surveys that differed in sponsors and the questions asked and did not provide comparable data. The 1995 data were from the CDC-sponsored Worksite Benchmark Survey.³⁴ This survey asked about provision of nutrition or cholesterol group classes, workshops, or lectures and weight management group classes, workshops, or lectures. Classes and counseling provided by health plans offered by the employer were not included.

See Part C for a description of NWHPS and Appendix A for focus area contact information.



19-17. Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet and nutrition.

National Data Source	National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 2.21 (Nutrition).
Measure	Percent (age adjusted—see Comments).
Baseline	42 (1997).
Numerator	Number of visits by ambulatory patients to non-Federal physicians in office-based practice with diagnosis of cardiovascular disease (ICD-9-CM codes 391-392.0, 393-398, 401, 402, 404, 410-416, 420-429), diabetes mellitus (ICD-9-CM code 250), or hyperlipidemia (ICD-9-CM codes 272.0-272.4), in which diet and nutrition counseling or education was ordered or provided.

Denominator	Number of visits by ambulatory patients to non-Federal physicians in office-based practice with diagnosis of cardiovascular disease, diabetes mellitus, or hyperlipidemia (as defined above).
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Ambulatory Medical Care Survey patient record:</p> <p>[Item 16:]</p> <p>➤ <i>Physician's diagnoses for this visit - as specifically as possible, list diagnoses related to this visit including chronic conditions (e.g., depression, obesity, asthma, etc.)</i> [Up to three diagnoses may be reported.]</p> <p>[Item 18:]</p> <p>➤ <i>Therapeutic and preventive services - check all ordered or provided at this visit. Exclude medications:</i> [Under the subheading "Counseling/education" a check box is provided for "Diet/Nutrition."]</p>
Expected Periodicity	Periodic.
Comments	<p>Because certain questions are rotated, update estimates may be available on a periodic rather than an annual basis.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 2.21, which was measured by the 1992 Primary Care Provider Survey and the 1997–98 Prevention in Primary Care Study. These surveys addressed the proportion of primary care providers who provided nutrition assessment and counseling to their patients. Referral to qualified nutritionists or dietitians, although part of the Healthy People 2000 objective, was never measured.</p> <p>See Part C for a description of NAMCS and Appendix A for focus area contact information.</p>



Food Security

19-18. Increase food security among U.S. households and in so doing reduce hunger.

National Data Source	Food Security Supplement to the Current Population Survey (CPS), DOC, U.S. Census Bureau.
State Data Source	Food Security Supplement to the Current Population Survey (CPS), DOC, U.S. Census Bureau.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	88 (1995).
Numerator	<p>Number of U.S. households that did not report experiencing food insecurity over a 12-month period.</p> <p>A proposed supplemental data source is the National Food and Nutrition Survey (NFNS), HHS and USDA, beginning in 2001. The NFNS questions will be identical to those asked by the Food Security Supplement to CPS.</p> <p>Although the NFNS will have a smaller sample size than the CPS Supplement, it will allow greater opportunities to explore relationships between food security and additional variables such as body mass index and specific diseases and health conditions.</p>
Denominator	Number of U.S. households during a 12-month period.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used to Obtain the National Data	<p>From the 1995 Food Security Supplement to the Current Population Survey:</p> <ul style="list-style-type: none">➤ <i>(I/we) worried whether our food would run out before (I/we) got money to buy more. Was that often, sometimes, or never true for you in the last 12 months?</i>➤ <i>The food that I/we bought just didn't last, and (I/we) didn't have money to get more. Was that often, sometimes or never true for you in the last 12 months?</i>➤ <i>(I/we) couldn't afford to eat balanced meals. Was that often, sometimes, or never true for you in the last 12 months?</i>

- *(I/we) relied on only a few kinds of low-cost food to feed the children because I/we were running out of money to buy food. Was that often, sometimes, or never true for you in the last 12 months?*
- *In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?*

[If yes:]

- *How often did this happen - almost every month, some months but not every month, or in only 1 or 2 months?*
- *(I/we) couldn't feed the children a balanced meal because (I/we) couldn't afford that. Was that often, sometimes, or never true for you in the last 12 months?*
- *In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?*
- *The children were not eating enough because (I/we) just couldn't afford enough food. Was that often, sometimes, or never true for you in the last 12 months?*
- *In the last 12 months, were you ever hungry but didn't eat because you couldn't afford enough food?*
- *Sometimes people lose weight because they don't have enough to eat. In the last 12 months, did you lose weight because there wasn't enough food?*
- *In the last 12 months, did you ever cut the size of any of the children's meals because there wasn't enough money for food?*
- *In the last 12 months, did you or other adults in your household ever not eat for a whole day because there wasn't enough money for food?*

[If yes:]

- *How often did this happen - almost every month, some months but not every month, or in only 1 or 2 months?*
- *In the last 12 months, were the children ever hungry but you just couldn't afford more food?*
- *In the last 12 months, did any of the children ever skip a meal because there wasn't enough money for food?*

[If yes:]

- *How often did this happen - almost every month, some month but not every month, or in only 1 or 2 months?*

- *In the last 12 months, did any of the children ever not eat for a whole day because there wasn't enough money for food?*

Expected Periodicity

Annual.

Comments

The 1995 Food Security Supplement to the Current Population Survey is a set of questions developed by an interagency working group led jointly by USDA's Food and Nutrition Service and HHS's National Center for Health Statistics.^{35, 36} All of the indicators of food insecurity in the Supplement focus explicitly on food insufficiency and hunger, at adult and child levels, resulting from inadequate household resources. Other sources of food insecurity, such as child abuse/neglect or loss of function or mobility (particularly relevant to the elderly population) are not distinguished by the measure.

The Food Security Supplement questions were asked of about 45,000 households as part of the 1995 Current Population Survey (a nationally representative sample selected and interviewed by the Census Bureau). This supplement was fielded for the first time in April 1995 and repeated in September 1996, April 1997, August 1998, and April 1999.

A statistical analysis of the survey responses identified a set of 18 core questions that were used to identify households with food insecurity.³⁷ Two separate measurement scales were developed: one for food insecurity during a 12-month period and another for insecurity for the past 30 days. The 12-month scale, which covers a broader range of food insecurity, was used for this objective. Households were classified as food secure if fewer than three of the questions were answered affirmatively or if only one or two questions were answered affirmatively. Otherwise, the household was classified as food insecure. An affirmative answer included "yes," "often," or "sometimes."

The Food Security Supplement also provides State-level estimates of food insecurity, which generally will be reported by the USDA based on 2- or 3-year averages.³⁸ The prevalence of hunger can also be tracked at the national and State levels.

See Appendix A for focus area contact information.

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20

Occupational Safety and Health

- 20-1 Work-related injury deaths
 - 20-1a All industries
 - 20-1b Mining
 - 20-1c Construction
 - 20-1d Transportation
 - 20-1e Agriculture, forestry, and fishing
- 20-2 Work-related injuries
 - 20-2a All industries
 - 20-2b Construction
 - 20-2c Health services
 - 20-2d Agriculture, forestry, and fishing
 - 20-2e Transportation
 - 20-2f Mining
 - 20-2g Manufacturing
 - 20-2h Adolescent workers
- 20-3 Overexertion or repetitive motion
- 20-4 Pneumoconiosis deaths
- 20-5 Work-related homicides
- 20-6 Work-related assaults
- 20-7 Elevated blood lead levels from work exposure
- 20-8 Occupational skin diseases or disorders
- 20-9 Worksite stress reduction programs
- 20-10 Needlestick injuries
- 20-11 Work-related, noise-induced hearing loss

20-1. Reduce deaths from work-related injuries.

20-1a. All industry.

National Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
State Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
Healthy People 2000 Objective	10.1 (Occupational Safety and Health).
Measure	Rate per 100,000 workers.
Baseline	4.5 (1998).
Numerator	Number of work-related injury deaths among workers aged 16 years and older.
Denominator	Average annual number of workers aged 16 years and older.
Population Targeted	U.S. resident population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1999 Current Population Survey:</p> <p>[DENOMINATOR:]</p> <p>➤ <i>Last week did you have a job, either full or part time?</i></p>
Expected Periodicity	Annual.
Comments	<p>CFOI uses multiple data sources including death certificates, workers' compensation reports, reports to various regulatory agencies, police reports, medical examiner records, as well as newspaper reports, to identify and verify work-related fatalities.</p> <p>The number of workers is reported in CPS, a monthly household survey that collects data on the employment status of the civilian, noninstitutionalized population aged 16 years and older. The number of workers includes full- and part-time workers, and is averaged over the calendar to account for seasonal and other variation.</p>

Information on the type of industry for the numerator is based on employer responses from CFOI. For the denominator, type of industry is determined from the response of the next of kin on the death certificate. The type of industry responses from CFOI and the death certificate are then converted to Standard Industrial Classification (SIC) codes.

See Appendix A for focus area contact information.



20.1b. Mining.

National Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
State Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
Healthy People 2000 Objective	10-1a (Occupational Safety and Health).
Measure	Rate per 100,000 workers in the mining industry.
Baseline	23.6 (1998).
Numerator	Number of work-related injury deaths among workers aged 16 years and older in the mining industry (SIC division B).
Denominator	Average annual number of workers in the mining industry (SIC division B).
Population Targeted	U.S. resident population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-1a.
Expected Periodicity	Annual.
Comments	See Comments provided with 20-1a for more information.



20-1c. Construction.

National Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
State Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
Healthy People 2000 Objective	10.1b (Occupational Safety and Health).
Measure	Rate per 100,000 workers in the construction industry.
Baseline	14.6 (1998).
Numerator	Number of work-related injury deaths among workers aged 16 years and older in the construction industry (SIC division C).
Denominator	Average annual number of workers in the construction industry (SIC division C).
Population Targeted	U.S. resident population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-1a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 20-1a for more information.



20-1d. Transportation.

National Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
State Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
Healthy People 2000 Objective	10.1c (Occupational Safety and Health).
Measure	Rate per 100,000 workers in the transportation industry.
Baseline	11.8 (1998).

Numerator	Number of work-related injury deaths among workers aged 16 years and older in the transportation industry (SIC division E).
Denominator	Average annual number of workers aged 16 years and older in the transportation industry (SIC division E).
Population Targeted	U.S. resident population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-1a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 20-1a for more information.



20-1e. Agriculture, forestry, and fishing.

National Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
State Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
Healthy People 2000 Objective	10.1d (Occupational Safety and Health).
Measure	Rate per 100,000 workers in the agriculture, forestry, and fishing industry.
Baseline	24.1 (1998).
Numerator	Number of work-related injury deaths among workers aged 16 years and older in the agriculture, forestry, and fishing industry (SIC division A).
Denominator	Average annual number of workers aged 16 years and older in the agriculture, forestry, and fishing industry (SIC division A).
Population Targeted	U.S. resident population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-1a.

Expected Periodicity	Annual.
Comments	See Comments provided with objective 20-1a for more information.



20-2. Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity.

20-2a. All industry.

National Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
State Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
Healthy People 2000 Objective	10.2 (Occupational Safety and Health).
Measure	Rate per 100 full-time workers.
Baseline	6.2 (1998).
Numerator	Number of reported nonfatal injuries among workers in all industries.
Denominator	Total number of hours worked by workers in all industries.
Population Targeted	Workers in private industry establishments—see Comments.
Questions Used To Obtain the National Data	<p>From the 1998 Annual Survey of Occupational Injuries and Illnesses:</p> <p>[NUMERATOR:]</p> <p><i>Copy these totals from your OSHA No. 200 form:</i></p> <ul style="list-style-type: none"> ➤ <i>Injuries with days away from work, restricted workdays or both</i> _____ ➤ <i>Injuries without lost workdays</i> _____ <p>[DENOMINATOR:]</p> <ul style="list-style-type: none"> ➤ <i>How many hours did your employees (salaried as well as hourly employees) actually work during 1998?</i>
Expected Periodicity	Annual.

Comments

The Annual Survey of Occupational Injuries and Illnesses is a Federal/State program in which employer reports are collected from approximately 164,000 private industry establishments. The survey measures nonfatal injuries and illnesses only and excludes the self-employed, farms with fewer than 11 employees, private households, and employees in Federal, State, and local government agencies.

Nonfatal occupational injuries are defined as any injury involving loss of consciousness, restriction of work or motion, transfer to another job, or medical treatment other than first aid. For this objective nonfatal occupational injuries include those to workers regardless of age that involve days away from work as well as those without lost workdays.

The rate per 100 full-time workers is computed by (1) dividing the number of occupational injuries reported by the total number of hours worked by all employees during the calendar year, and (2) multiplying the result by 200,000. The factor 200,000 represents the hours worked in a year by 100 full-time equivalent workers (working 40 hours work per week, 50 weeks a year).

Information on the type of industry for the numerator is based on employer responses and converted to Standard Industrial Classification codes.

See Appendix A for focus area contact information.



20-2b. Construction.

National Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
State Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
Healthy People 2000 Objective	10.2a (Occupational Safety and Health).
Measure	Rate per 100 full-time workers in the construction industry.
Baseline	8.7 (1998).

Numerator	Number of reported nonfatal injuries among workers in the construction industry (SIC division C).
Denominator	Total number of hours worked by workers in the construction industry (SIC division C).
Population Targeted	Workers in private industry establishments—see Comments.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-2a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 20-2a for more information.



20-2c. Health services.

National Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
State Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
Healthy People 2000 Objective	10.2b (Occupational Safety and Health).
Measure	Rate per 100 full-time workers in the health services industry.
Baseline	7.9 (1997).
Numerator	Number of reported injuries among workers in the health services industry (SIC Major Group 80).
Denominator	Total number of hours worked by workers in the health services industry (SIC Major Group 80).
Population Targeted	Workers in private industry establishments—see Comments.
Questions Used to Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-2a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 20-2a for more information.

20-2d. Agriculture, forestry, and fishing.

National Data Source	Annual Survey of Occupational Injuries and Illnesses, DOL, BLS.
State Data Source	Annual Survey of Occupational Injuries and Illnesses, DOL, BLS.
Healthy People 2000 Objective	10.2c (Occupational Safety and Health).
Measure	Rate reported per 100 full-time workers among workers in the agricultural, forestry, and fishing industry.
Baseline	7.6 (1998).
Numerator	Number of reported injuries in the agriculture, forestry, and fishing industry (SIC division A).
Denominator	Total number of hours worked by workers in the agriculture, forestry, and fishing industry (SIC division A).
Population Targeted	Workers in private industry establishments—see Comments.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-2a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 20-2a for more information.



20-2e. Transportation.

National Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
State Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
Healthy People 2000 Objective	10.2d (Occupational Safety and Health).
Measure	Rate per 100 full-time workers in the transportation industry.

Baseline	7.9 (1997).
Numerator	Number of reported injuries among workers in the transportation industry (SIC division E).
Denominator	Total number of hours worked by workers in the transportation industry (SIC division E).
Population Targeted	Workers in private industry establishments—see Comments.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-2a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 20-2a for more information.



20-2f. Mining.

National Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
State Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
Healthy People 2000 Objective	10.2e (Occupational Safety and Health).
Measure	Rate per 100 full-time workers in the mining industry.
Baseline	4.7 (1998).
Numerator	Number of reported injuries among workers in the mining industry (SIC division B).
Denominator	Total number of hours worked by workers in the mining industry (SIC division B).
Population Targeted	Workers in private industry establishments—see Comments.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-2a.
Expected Periodicity	Annual.

Comments	See Comments provided with objective 20-2a for more information.
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20-2g. Manufacturing.

National Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
State Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
Healthy People 2000 Objective	Adapted from 10.2 (Occupational Safety and Health).
Measure	Rate per 100 full-time workers in the manufacturing industry.
Baseline	8.5 (1998).
Numerator	Number of reported injuries among workers in the manufacturing industry (SIC division D).
Denominator	Total number of hours worked by workers in the manufacturing industry (SIC division D).
Population Targeted	Workers in private industry establishments—see Comments.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-2a.
Expected Periodicity	Annual.
Comments	The Annual Survey of Occupational Injuries and Illnesses is a Federal/State program in which employer reports are collected from approximately 164,000 private industry establishments. The survey measures nonfatal injuries and illnesses only and excludes the self-employed, farms with fewer than 11 employees, private households, and employees in Federal, State, and local government agencies.

Nonfatal occupational injuries are defined as any injury involving loss of consciousness, restriction of work or motion, transfer to another job, or medical treatment other than first aid. For this objective nonfatal occupational injuries include those to workers regardless of age that involve days away from work as well as those without lost workdays.

The rate per 100 full-time workers is computed by dividing the number of occupational injuries reported by the total number of hours worked by all employees during the calendar year, multiplied by 200,000. The factor 200,000 represents the hours worked in a year by 100 full-time equivalent workers (working 40 hours work per week, 50 weeks a year).

Information on the type of industry for the numerator is based on employer responses and converted to Standard Industrial Classification codes.

This objective differs from Healthy People 2000 objective 10.2, which tracked nonfatal, work-related injuries in various industries. This objective tracks nonfatal, work-related injuries in the manufacturing industry, which was not previously a separately tracked industry.

See Appendix A for focus area contact information.



20-2h. Adolescent workers.

National Data Source	National Electronic Injury Surveillance System (NEISS), CPSC and NIOSH.
State Data Source	Not identified.
Healthy People 2000 Objective	10.2f (Occupational Safety and Health).
Measure	Rate per 100 adolescent workers.
Baseline	4.8 (1997).
Numerator	Number of work-related injuries among workers aged 15 to 17 years as reported in hospital emergency department records.
Denominator	Total number of hours worked by workers aged 15 to 17 years.

Population Targeted	U.S. resident population; U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1999 Current Population Survey:</p> <p>[DENOMINATOR:]</p> <ul style="list-style-type: none"> ➤ <i>Last week did you have a job, either full or part time?</i> ➤ <i>Last week how many hours did you actually work at your job?</i>

Expected Periodicity Periodic.

Comments NEISS data are based on work-related injury data reported in a national sample of hospital emergency departments. Coders report only those injuries that are designated as “work-related.”

The denominator is taken from the Current Population Survey, a monthly household survey that collects data on the employment status of the civilian, noninstitutionalized population. Unpublished data are available for persons aged 15 years; these data are combined with the standard CPS data for persons aged 16 to 17 years.

The rate per 100 full-time adolescent workers is computed by multiplying the number of injuries reported to workers aged 15 to 17 years divided by the total hours worked by employees aged 15 to 17 years during the calendar year, multiplied by 200,000. The factor 200,000 represents the hours worked in a year by 100 full-time equivalent workers (working 40 hours work per week, 50 weeks a year).

The baseline data are based on fiscal year 1997, though labeled 1996. Future rates will be based on calendar years due to changes in the weighting strategy for the NEISS hospitals.

See Appendix A for focus area contact information.



20-3. Reduce the rate of injury and illness cases involving days away from work due to overexertion or repetitive motion.

National Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
State Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
Healthy People 2000 Objective	10.3 (Occupational Safety and Health).
Measure	Rate per 100,000 workers.
Baseline	675 (1997).
Numerator	Number of reported nonfatal occupational injuries and illnesses due to overexertion or repetitive motion involving days away from work among workers aged 16 years and older.
Denominator	Total number of hours worked by workers aged 16 years and older.
Population Targeted	Workers in private industry establishments—see Comments.
Questions Used To Obtain the National Data	<p>From the 1998 Annual Survey of Occupational Injuries and Illnesses:</p> <p>[NUMERATOR:]</p> <p><i>Copy these totals from your OSHA No. 200 form:</i></p> <ul style="list-style-type: none">➤ <i>Injuries with days away from work, restricted workdays or both _____</i>➤ <i>Injuries without lost workdays _____</i>➤ <i>Disorders associated with repeated trauma ____.</i> <p>[DENOMINATOR:]</p> <ul style="list-style-type: none">➤ <i>How many hours did your employees (salaried as well as hourly employees) actually work during 1998?</i>
Expected Periodicity	Annual.
Comments	<p>See Comments provided with objective 20-2a for more information.</p> <p>The computation of this measure is the same as for 20-2a except the multiplication factor is 200,000,000 instead of 200,000, in order to produce a rate per 100,000.</p>

See Appendix A for focus area contact information.



20-4. Reduce pneumoconiosis deaths.

National Data Source	National Surveillance System for Pneumoconiosis Mortality (NSSPM), CDC, NIOSH.
State Data Source	National Surveillance System for Pneumoconiosis Mortality (NSSPM), CDC, NIOSH.
Healthy People 2000 Objective	10.17 (Occupational Safety and Health).
Measure	Number of deaths.
Baseline	2,928 (1997).
Numerator	Number of deaths for occupation-related pneumoconiosis (ICD-9 codes 500-505).
Denominator	Not applicable.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	Data are restricted to those decedents aged 15 years and older in order to represent working members of the population and to exclude those unlikely to be associated with occupational exposure. See Appendix A for focus area contact information.



20-5. Reduce deaths from work-related homicides.

National Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.
State Data Source	Census of Fatal Occupational Injuries (CFOI), DOL, BLS.

Healthy People 2000 Objective	10.16 (Occupational Safety and Health).
Measure	Rate per 100,000 workers.
Baseline	0.5 (1998).
Numerator	Number of deaths due to work-related homicides among workers aged 16 years and older.
Denominator	Average annual number of workers aged 16 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 20-1a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 20-1a for more information. See Appendix A for focus area contact information.



20-6. Reduce work-related assaults.

National Data Source	National Crime Victimization Survey (NCVS), DOJ, BJS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100 workers.
Baseline	0.85 (1987–92).
Numerator	Number of persons who report being the victim of an assault (see Comments) while working or on duty.
Denominator	Average annual number of workers aged 16 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Crime Victimization Survey:

[NUMERATOR:]

- *What were you doing when this incident occurred?*

[Response categories include:]

_____ *Working or on duty*

- *Other than any incidents already mentioned, has anyone attacked or threatened you in any of these ways:*

a) With any weapon, for instance, a gun, or knife-

b) With anything like a baseball bat, frying pan, scissors, or stick-

c) By something thrown, such as a rock or bottle-

d) Include any grabbing, punching, or choking-

e) Any rape, attempted rape, or other type of sexual attack-

f) Any face to face threats-

OR

g) Any attack or threat or use of force by anyone at all?

Please mention it even if you are not certain that it was a crime.

(Briefly describe incident.)

From the 1998 Current Population Survey:

[DENOMINATOR:]

- *Last week did you have a job, either full or part time?*

Expected Periodicity

Annual.

Comments

For this objective, assault includes a response of "yes" to any of the assault categories listed in the questions above and a response that the assault occurred while working or on duty. Assault occurring on the way to or from work was not included.

See Comments provided with objective 20-1a for more information.

See Appendix A for focus area contact information.



20-7. Reduce the number of persons who have elevated blood lead concentrations from work exposures.

National Data Source

Adult Blood Lead Epidemiology and Surveillance Program (ABLES), CDC, NIOSH.

State Data Source

Adult Blood Lead Epidemiology and Surveillance Program (ABLES), CDC, NIOSH.

Healthy People 2000 Objective	Adapted from 10.8 (Occupational Safety and Health).
Measure	Rate per million persons.
Baseline	93 (1998) (25 States—see Comments).
Numerator	Number of adults aged 16 to 64 years with blood lead levels >25 µg/dL in States that participate in the ABLES program.
Denominator	Number of adults aged 16 to 64 residing in ABLES States.
Population Targeted	Selected States—see Comments.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Twenty-five States reported 10,501 adults aged 16 to 64 years with blood lead levels of 25 µg/dL or greater in 1998. This objective differs from Healthy People 2000 objective 10.8 in that it tracks the rate per million in ABLES States as a measure; 10.8 tracked the number of adults with blood lead levels greater than 25 µg in ABLES States.</p> <p>See Appendix A for focus area contact information.</p>



20-8. Reduce occupational skin diseases or disorders among full-time workers.

National Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
State Data Source	Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS.
Healthy People 2000 Objective	10.4 (Occupational Safety and Health).
Measure	Rate per 100,000 full-time workers.
Baseline	67 (1997).
Numerator	Number of reported nonfatal occupational illnesses due to work-related skin disease and disorders among workers in all industries.

Denominator	Total number of hours worked by workers in all industries.
Population Targeted	Workers in private industry establishments—see Comments.
Questions Used To Obtain the National Data	From the 1998 Annual Survey of Occupational Injuries and Illnesses: <ul style="list-style-type: none"> ➤ <i>Copy the totals from your OSHA No. 200 form:</i> ➤ <i>Skin diseases or disorders ____</i>
Expected Periodicity	Annual.
Comments	<p>See Comments provided with objective 20-2a for more information.</p> <p>The computation of this measure is the same as for 20-2a except the multiplication factor is 200,000,000 instead of 200,000, in order to produce a rate per 100,000.</p> <p>For this objective nonfatal occupational skin diseases or disorders include those to workers regardless of age that involve days away from work as well as those without lost workdays.</p> <p>See Appendix A for focus area contact information.</p>



20-9. Increase the proportion of worksites employing 50 or more persons that provide programs to prevent or reduce employee stress.

National Data Source	National Survey of Worksite Health Promotion Activities (NSWHP), Association for Worksite Health Promotion and OPHS, ODPHP.
State Data Source	Not identified.
Healthy People 2000 Objective	6.11 (Mental Health and Mental Disorders).
Measure	Percent.
Baseline	37 (1992).
Numerator	Number of worksites that provide programs to prevent or reduce employee stress.
Denominator	Number of worksites surveyed.

Questions Used To Obtain the National Data

From the 1992 National Survey of Worksite Health Promotion Activities:

- *During the past 12 months, did your worksite offer any information or activities concerning stress management?*

If yes:

- *Which of the following was offered related to stress management?*

Individual classes

Group classes

Resource materials, such as brochures, pamphlets or videos

Job redesign, personnel reassignment

Expected Periodicity

Periodic.

Comments

The baseline was set using data from the 1992 National Survey of Worksite Health Promotion Activities, which collected data from the private sector and may not accurately reflect the practices of public sector organizations.

Data from the 1999 National Worksite Health Promotion Survey reported that only 26 percent of worksites offered worksite-based stress management programs, but that 48 percent offered stress management either in the worksite or through their health care programs. NIOSH is currently planning data collection efforts to better understand stress prevention activities in both public and private workplaces.

See Appendix A for focus area contact information.



20-10. Reduce occupational needlestick injuries among health care workers.

National Data Source

National Surveillance System for Hospital Health Care Workers (NaSH), CDC, NCID.

State Data Source

Not identified.

Healthy People 2000 Objective

Not applicable.

Measure

Number of needlestick injuries.

Baseline	600,000 (1996).
Numerator	Number of needlestick injuries among health care workers.
Denominator	Not applicable.
Population Targeted	Health care workers.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Estimates for the United States will be based on the sample of U.S. hospitals that voluntarily participate in the NaSH program.</p> <p>See Appendix A for focus area contact information.</p>



20-11. (Developmental) Reduce new cases of work-related, noise-induced hearing loss.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>The proposed national data source is Annual Survey of Occupational Injuries and Illnesses, BLS, DOL.</p> <p>This objective is adapted from Healthy People 2000 objective 10.7 which used data from the U.S. Air Force Hearing Conservation database.</p> <p>See Appendix A for focus area contact information.</p>
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21

Oral Health

- 21-1 Dental caries experience
 - 21-1a Children aged 2 to 4 years
 - 21-1b Children aged 6 to 8 years
 - 21-1c Adolescents aged 15 years
- 21-2 Untreated dental decay
 - 21-2a Children aged 2 to 4 years
 - 21-2b Children aged 6 to 8 years
 - 21-2c Adolescents aged 15 years
 - 21-2d Adults aged 35 to 44 years
- 21-3 No permanent tooth loss
- 21-4 Complete tooth loss
- 21-5 Periodontal diseases
 - 21-5a Gingivitis
 - 21-5b Destructive periodontal disease
- 21-6 Early detection of oral and pharyngeal cancers
- 21-7 Annual examinations for oral and pharyngeal cancers
- 21-8 Dental sealants
 - 21-8a Children aged 8 years
 - 21-8b Adolescents aged 14 years
- 21-9 Community water fluoridation
- 21-10 Use of oral health care system
- 21-11 Use of oral health care system by residents in long-term care facilities
- 21-12 Dental services for low-income children
- 21-13 School-based health centers with oral health component
- 21-14 Health centers with oral health service component
- 21-15 Referral for cleft lip or palate
- 21-16 Oral and craniofacial State-based surveillance system
- 21-17 Tribal, State, and local dental programs

21-1. Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth.

21-1a. Reduce the proportion of young children with dental caries experience in their primary teeth.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 13.1 (Oral Health).
Measure	Percent.
Baseline	18 (1988–94).
Numerator	Number of children aged 2 to 4 years with a clinical diagnosis of dental caries, presence of fillings in at least one primary tooth, or evidence of a missing tooth due to caries.
Denominator	Number of children aged 2 to 4 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>Although this objective uses the same measurement protocol as the comparable Healthy People 2000 objective 13.1, the tracking of young children aged 2 to 4 years is new to Healthy People 2010.</p> <p>A description of the clinical protocol used to diagnose caries experience for Healthy People 2000 has been published by NCHS.¹</p> <p>See Part C for a description of NHANES.</p>

Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. IHS collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.

Baseline data for the Asian population are from the 1993–94 California Oral Health Needs Assessment of Children. This data set was used because it had the largest representative sample of Asian children in which clinical oral health status indicators were assessed. Data were collected from a representative sample of California children in schools by trained examiners.

See Appendix A for focus area contact information.



21-1b. Reduce the proportion of children with dental caries experience in primary and permanent teeth.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	13.1 (Oral Health).
Measure	Percent.
Baseline	52 (1988–94).
Numerator	Number of children aged 6 to 8 years with a clinical diagnosis of dental caries, presence of fillings in at least one primary or permanent tooth, or evidence of a missing tooth due to caries.
Denominator	Number of children aged 6 to 8 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.

Comments

This objective uses the same measurement protocol as the comparable Healthy People 2000 objective 13.1. A description of the clinical protocol used to diagnose caries experience for Healthy People 2000 has been published by NCHS.¹

See Part C for a description of NHANES.

Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. IHS collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.

Baseline data for the Asian population are from the 1993–94 California Oral Health Needs Assessment of Children. This data set was used because it had the largest representative sample of Asian children in which clinical oral health status indicators were assessed. Data were collected from a representative sample of California children in schools by trained examiners.

Baseline data for the Native Hawaiian and other Pacific Islander population are from the 1999 Hawai'i Children's Oral Health Assessment. The Hawaii State Department of Health collects oral health data of school children periodically (previously in 1998). In 1999 25,553 school children aged 5 to 11 years were surveyed. Data were collected by calibrated examiners from a representative sample of Hawaii children attending public schools.

See Appendix A for focus area contact information.



21-1c. Reduce the proportion of adolescents with dental caries experience in their permanent teeth.

National Data Source National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

State Data Source Not identified.

Healthy People 2000 Objective	13.1 (Oral Health).
Measure	Percent.
Baseline	61 (1988–94).
Numerator	Number of adolescents aged 15 years with a clinical diagnosis of dental caries, presence of fillings in at least one permanent tooth, or evidence of a missing permanent tooth due to caries.
Denominator	Number of adolescents aged 15 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>This objective uses the same measurement protocol as the comparable Healthy People 2000 objective 13.1. A description of the clinical protocol used to diagnose caries experience for Healthy People 2000 has been published by NCHS.¹</p> <p>See Part C for a description of NHANES.</p> <p>Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. IHS collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.</p> <p>Baseline data for the Asian population are from the 1993–94 California Oral Health Needs Assessment of Children. This data set was used because it had the largest representative sample of Asian children for which clinical oral health status indicators were assessed. Data were collected from a representative sample of California children in schools by trained examiners.</p> <p>See Appendix A for focus area contact information.</p>



21-2. Reduce the proportion of children, adolescents, and adults with untreated dental decay.

21-2a. Reduce the proportion of young children with untreated dental decay in their primary teeth.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 13.2 (Oral Health).
Measure	Percent.
Baseline	16 (1988–94).
Numerator	Number children aged 2 to 4 years with a clinical diagnosis of dental decay in at least one tooth that has not been restored.
Denominator	Number of children aged 2 to 4 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>Although this objective uses the same measurement protocol as the comparable Healthy People 2000 objective 13.2, the tracking of young children aged 2 to 4 years is new to Healthy People 2010.</p> <p>A description of the clinical protocol used to diagnose dental decay for Healthy People 2000 has been published by NCHS.¹</p> <p>See Part C for a description of NHANES.</p> <p>Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. IHS collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.</p>

Baseline data for the Asian population are from the 1993–94 California Oral Health Needs Assessment of Children. This data set was used because it had the largest representative sample of Asian children for which clinical oral health status indicators were assessed. Data were collected from a representative sample of California children in schools by trained examiners.

See Appendix A for focus area contact information.



21-2b. Reduce the proportion of children with untreated dental decay in their primary teeth and permanent teeth.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	13.2 (Oral Health).
Measure	Percent.
Baseline	29 (1988–94).
Numerator	Number of children aged 6 to 8 years with a clinical diagnosis of dental decay in at least one primary or permanent tooth that has not been restored.
Denominator	Number of children aged 6 to 8 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>This objective uses the same measurement protocol as the comparable Healthy People 2000 objective 13.2. A description of the clinical protocol used to diagnose dental decay for Healthy People 2000 has been published by NCHS.¹</p> <p>See Part C for a description of NHANES.</p>

Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. IHS collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.

Baseline data for the Asian population are from the 1993–94 California Oral Health Needs Assessment of Children. This data set was used because it had the largest representative sample of Asian children in which clinical oral health status indicators were assessed. Data were collected from a representative sample of California children in schools by trained examiners.

Baseline data for the Native Hawaiian and other Pacific Islander population are from the 1999 Hawai'i Children's Oral Health Assessment. The Hawaii State Department of Health collects oral health data of school children periodically (previously in 1998). In 1999 25,553 school children aged 5 to 11 years were surveyed. Data were collected by calibrated examiners from a representative sample of Hawaii children attending public schools.

See Appendix A for focus area contact information.



21-2c. Reduce the proportion of adolescents with untreated dental decay in their permanent teeth.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	13.2 (Oral Health).
Measure	Percent.
Baseline	20 (1988–94).
Numerator	Number of adolescents aged 15 years with a clinical diagnosis of dental decay in at least one permanent tooth that has not been restored.

Denominator	Number of adolescents aged 15 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>This objective uses the same measurement protocol as the comparable Healthy People 2000 objective 13.2. A description of the clinical protocol used to diagnose dental decay for Healthy People 2000 has been published by NCHS.¹</p> <p>See Part C for a description of NHANES.</p> <p>Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. IHS collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.</p> <p>Baseline data for the Asian population are from the 1993–94 California Oral Health Needs Assessment of Children. This data set was used because it had the largest representative sample of Asian children in which clinical oral health status indicators were assessed. Data were collected from a representative sample of California schoolchildren in schools by trained examiners.</p> <p>See Appendix A for focus area contact information.</p>



21-2d. Reduce the proportion of adults with untreated dental decay.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 13.2 (Oral Health).
Measure	Percent.

Baseline	27 (1988-94).
Numerator	Number of adults aged 35 to 44 years with a clinical diagnosis of dental decay in at least tooth that has not been restored.
Denominator	Number of adults aged 35 to 44 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>Although this objective uses the same measurement protocol as the comparable Healthy People 2000 objective 13.2, the tracking of adults aged 35 to 44 years is new to Healthy People 2010.</p> <p>A description of the clinical protocol used to diagnose dental decay for Healthy People 2000 has been published by NCHS.¹</p> <p>See Part C for a description of NHANES.</p> <p>Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. IHS collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.</p> <p>See Appendix A for focus area contact information.</p>



21-3. Increase the proportion of adults who have never had a permanent tooth extracted because of dental caries or periodontal disease.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	13.3 (Oral Health).

Measure	Percent.
Baseline	31 (1988–94).
Numerator	Number of adults aged 35 to 44 with a clinical confirmation of at least 28 natural teeth, exclusive of third molars.
Denominator	Number of adults aged 35 to 44 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>Case definition is “no teeth lost due to caries or periodontal diseases”; however, because cause of tooth loss is not feasible to identify, the presence of 28 natural teeth (excluding third molars) is used as a proxy.</p> <p>See Part C for a description of NHANES.</p> <p>Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. The Indian Health Service (IHS) collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.</p> <p>See Appendix A for focus area contact information.</p>



21-4. Reduce the proportion of older adults who have had all their natural teeth extracted.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 13.4 (Oral Health).
Measure	Percent.
Baseline	26 (1997).

Numerator	Number of older adults aged 65 to 74 years who report having lost all their natural teeth.
Denominator	Number of adults aged 65 to 74 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Health Interview Survey:</p> <ul style="list-style-type: none"> ➤ <i>Have you lost all of your upper natural (permanent) teeth?</i> ➤ <i>Have you lost all of your lower natural (permanent) teeth?</i>
Expected Periodicity	Periodic.
Comments	<p>A person is defined as having lost all their natural teeth if they answered “yes” to both of the preceding questions.</p> <p>Although the same measurement is used to track this objective and the comparable Healthy People 2000 objective 13.4, data for the Healthy People 2010 objective are restricted to older adults aged 65 to 74 years while the Healthy People 2000 data cover all older adults aged 65 years and older.</p> <p>A description of the comparable Healthy People 2000 objective 13.4 has been published by NCHS.¹</p> <p>See Part C for a description of NHIS.</p> <p>Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. The Indian Health Service (IHS) collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.</p> <p>See Appendix A for focus area contact information.</p>



21-5. Reduce periodontal disease.

21-5a. Gingivitis.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 13.5 (Oral Health).
Measure	Percent.
Baseline	48 (1988–94).
Numerator	Number of adults aged 35 to 44 years with a clinical confirmation of gingivitis.
Denominator	Number of adults aged 35 to 44 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>Gingivitis is gingival bleeding in one or more sites after gently probing the gingival sulcus.</p> <p>A description of the comparable Healthy People 2000 objective 13.5, which included the clinical protocol used to diagnose gingivitis has been published by NCHS.¹</p> <p>The same measurement is used to track this objective and the comparable Healthy People 2000 objective 13.5. However, published data for the Healthy People 2000 objective were restricted to employed adults while the Healthy People 2010 data covers all noninstitutionalized individuals aged 35 to 44 years.</p> <p>See Part C for a description of NHANES.</p>

Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. The Indian Health Service (IHS) collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.

See Appendix A for focus area contact information.



21-5b. Destructive periodontal disease.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 13.6 (Oral Health).
Measure	Percent.
Baseline	22 (1988–94).
Numerator	Number of adults aged 35 to 44 years with a clinical diagnosis of destructive periodontal disease.
Denominator	Number of adults aged 35 to 44 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	Destructive periodontal disease is the loss of attachment greater than or equal to 4mm in two sites on at least one tooth—as measured at the mid-facial and mesial facial line angles for two quadrants. These two quadrants include one randomly selected quadrant in the maxillary arch and one quadrant in the mandibular arch.

Although a similar measurement is used to track the comparable Healthy People 2000 objective 13.6, published data for the Healthy People 2000 objective were restricted to employed adults, while the Healthy People 2010 data covers all noninstitutionalized adults aged 35 to 44 years.

A description of the clinical protocol used to diagnose destructive periodontal disease in Healthy People 2000 has been published by NCHS.¹

See Part C for a description of NHANES.

Baseline data for the American Indian/Alaska Native population are from the 1999 Oral Health Survey of Native Americans. The Indian Health Service (IHS) collects data approximately every 10 years on the American Indian/Alaska Native population. Data are collected on clinic users to assess the oral health status and treatment needs of the IHS service area population. The data reflect a weighted sample.

See Appendix A for focus area contact information.



21-6. Increase the proportion of oral and pharyngeal cancers detected at the earliest stage.

National Data Source	Surveillance, Epidemiology, and End Results Program (SEER), NIH, NCI.
State Data Source	State cancer registries.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	35 (1990–95) (selected areas—see Comments).
Numerator	Number of diagnosed incidents of cancer cases in stage 1 (localized) of the oral cavity and pharynx (ICD-9 codes 140-149).
Denominator	Number of diagnosed incidents of all cancer cases of the oral cavity and pharynx (ICD-9 codes 140-149).
Population Targeted	Resident population (selected areas—see Comments).

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>SEER data are based on data from population-based registries in Connecticut; New Mexico; Utah; Iowa; Hawaii; Atlanta, GA; Detroit, MI; Seattle-Puget Sound, WA; and San Francisco-Oakland, CA.</p> <p>A description of the SEER program has been published by NCI.²</p> <p>See Appendix A for focus area contact information.</p>



21-7. Increase the proportion of adults who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancers.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	13 (1998).
Numerator	Number of adults aged 40 years and older who report having had an examination to detect oral and pharyngeal cancer in the past 12 months.
Denominator	Number of adults aged 40 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>➤ <i>Have you ever had a test for oral cancer in which the doctor or dentist pulls on your tongue, sometimes with gauze wrapped around it, and feels under the tongue and inside the cheeks?</i></p>

[If yes:]

- *When did you have your most recent oral cancer exam? Was it a year ago or less, more than 1 year but not more than 2 years, more than 2 years but not more than 3 years, more than 3 years but not more than 5 years, or over 5 years ago?*

Expected Periodicity Periodic.

Comments A person is defined as having had an oral and pharyngeal cancer test in the past 12 months if he/she responded “yes” to the first question and “a year ago or less” to the second question listed above.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion of age adjustment, see Part A, section 5.

See Part C for a description of NHIS and Appendix A for focus area contact information.



21-8. Increase the proportion of children who have received dental sealants on their molar teeth.

21-8a. Children aged 8 years.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	13.8 (Oral Health).
Measure	Percent.
Baseline	23 (1988–94).
Numerator	Number of children aged 8 years with a clinical confirmation of dental sealants applied to one or more permanent molars.
Denominator	Number of children aged 8 years.
Population Targeted	U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>A description of the clinical protocol used to confirm evidence of protective dental sealants has been published by NCHS.¹</p> <p>See Part C for a description of NHANES.</p> <p>Baseline data for the Native Hawaiian and other Pacific Islander population are from the 1999 Hawai'i Children's Oral Health Assessment. The Hawaii State Department of Health collects oral health data of school children periodically (previously in 1998). In 1999 25,553 school children aged 5 to 11 years were surveyed. Data were collected by calibrated examiners from a representative sample of Hawaii children attending public schools.</p> <p>See Appendix A for focus area contact information.</p>



21-8b. Adolescents aged 14 years.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 13.8 (Oral Health).
Measure	Percent.
Baseline	15 (1988–94).
Numerator	Number of adolescents aged 14 years with a clinical confirmation of dental sealants applied to one or more first and second permanent molars.
Denominator	Number of adolescents aged 14 years with at least one permanent first molar and one permanent second molar.
Population Targeted	U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with 1999 data.
Comments	<p>A description of the clinical protocol used to confirm evidence of protective dental sealants has been published by NCHS.¹</p> <p>Although the same measurement is used to track this objective and the comparable Healthy People 2000 objective 13.8, the Healthy People 2010 data are limited to protective sealant data on one or more permanent first and second molars, while data for the Healthy People 2000 objective did not distinguish between first and second permanent molars.</p> <p>See Part C for a description of NHANES and Appendix A for focus area contact information.</p>



21-9. Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water.

National Data Source	CDC Fluoridation Census, CDC, NCCDPHP.
State Data Source	CDC Fluoridation Census, CDC, NCCDPHP.
Healthy People 2000 Objective	13.9 (Oral Health).
Measure	Percent.
Baseline	62 (1992).
Numerator	Number of persons receiving optimally fluoridated water from public systems.
Denominator	Number of persons served by public water systems.
Population Targeted	U.S. resident population served by public water systems.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual, beginning with year 2000 data.

Comments

Optimal water concentration of fluoride is specific for geographic areas, based on their mean daily temperature.

A description of the protocol used to characterize a community as optimally fluoridated has been published by NCHS.¹

Beginning with year 2000 data, the source of data will be an interactive Web-based surveillance system called the Water Fluoridation Reporting System. This voluntary reporting system obtains information from the local water system on the number of people served by the fluoridated water system, the number of counties and cities served by the fluoridated water system, and the quality of the fluoridated water system. These quality measures will include the number of months the system is operating with optimal fluoride concentration. CDC will produce an annual report from the database.

See Appendix A for focus area contact information.

**21-10. Increase the proportion of children and adults who use the oral health care system each year.**

National Data Source	Medical Expenditure Panel Survey (MEPS), AHRQ (formerly AHCPH).
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 13.14 (Oral Health).
Measure	Percent.
Baseline	44 (1996).
Numerator	Number of persons aged 2 years and older who report having had a dental visit in the past 12 months.
Denominator	Number of persons aged 2 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1996 Medical Expenditure Panel Survey. See http://www.meps.ahrq.gov/survey.htm for more information.

Expected Periodicity	Periodic.
Comments	<p>MEPS data provide information on the nature of the dental visit as well as dental insurance status of the patient. MEPS data are also used for objective 21-12—preventive dental visits for poor children. MEPS data provide a comprehensive assessment of a previous dental visit. Subjects are interviewed on five different occasions over 15 months, so that they do not need to recall details of dental care received more than 3 months beforehand. In addition, MEPS subjects are also asked for specific information about care received at each visit. Therefore, the numbers of visits during a year are substantiated with additional corroborating evidence. MEPS is used as the database for dental visits in the April 2000 Government Accounting Office report to Congress on access to dental care.</p> <p>This objective differs from a similar Healthy People 2000 objective 13.14. The Healthy People 2000 objective was tracked by the NHIS and was restricted to adults aged 35 years and older, while the Healthy People 2010 objective covers all noninstitutionalized persons aged 2 years and older. A report on the operational definitions for the Healthy People 2000 oral health objectives has been published by NCHS.¹</p> <p>See Part C for a description of MEPS and Appendix A for focus area contact information.</p>



21-11. Increase the proportion of long-term care residents who use the oral health care system each year.

National Data Source	National Nursing Home Survey (NNHS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	19 (1997).

Numerator	Number of nursing home residents who used the oral health care system.
Denominator	Number of nursing home residents.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	<p>From the 1997 National Nursing Home Survey:</p> <p>[In the question below, the phrase “last month” was used if the resident was admitted in the previous month or earlier. The phrase “since admission” was used if the resident was admitted in the current month.]</p> <p>➤ <i>(Last month/since admission) which of these services were received by (<u>Resident</u>), either inside or outside of this facility?</i></p> <p>[A “hand flashcard” is supplied with a check box for “Dental care.”]</p>
Expected Periodicity	Periodic.
Comments	<p>A nursing home resident was considered to have used the oral health care system if the respondent indicated Dental care was provided.</p> <p>Nursing home data were used as proxy data for long-term care facilities since there is no known database that enumerates all long-term care facilities (nursing homes, chronic disease hospitals, etc.).</p> <p>A description of the 1997 National Nursing Home Survey has been published by NCHS.³</p> <p>See Appendix A for focus area contact information.</p>



21-12. Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.

National Data Source	Medical Expenditure Panel Survey (MEPS), AHQR (formerly AHCPR).
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.

Baseline	20 (1996).
Numerator	Number of children under age 19 years at or below 200 percent of the Federal poverty level who received a preventive dental visit during the last year.
Denominator	Number of children under age 19 years at or below 200 percent of the Federal poverty level.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1996 Medical Expenditure Panel Survey. See www.meps.ahrq.gov/survey.htm for more information.
Expected Periodicity	Periodic.
Comments	<p>A preventive dental visit is defined as receiving a dental sealant, fluoride treatment, or dental prophylaxis.</p> <p>See Comments with objective 21-10 for more information on MEPS. A description of the 1996 MEPS has been published by AHRQ (formerly HCPR).⁴</p> <p>See Part C for a description of MEPS and Appendix A for focus area contact information.</p>



21-13. (Developmental) Increase the proportion of school-based health centers with an oral health component.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>The School Health Policies and Program Study (SHPPS), CDC, NCCDPHP, is a proposed data source since questions addressing oral health have recently been added. Baseline data are anticipated from the 2000 SHPPS.</p> <p>See Appendix A for focus area contact information.</p>
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21-14. Increase the proportion of local health departments and community-based health centers, including community, migrant, and homeless health centers, that have an oral health component.

National Data Source	Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC).
State Data Source	Association of State and Territorial Dental Directors (ASTDD).
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	34 (1997).
Numerator	Number of local health departments and community-based health centers that have an oral health component.
Denominator	Number of local health departments and community-based health centers.
Questions Used To Obtain the National Data	Not applicable.
Comments	<p>In order to be considered as having an oral health component, a physical office must be identified in which dental services are provided on-site by a dentist. If a center or local health department provides contract dental services, at least 700 people must be served annually.</p> <p>See Appendix A for focus area contact information.</p>



21-15. Increase the number of States and the District of Columbia that have a system for recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies to craniofacial anomaly rehabilitative teams.

Comments	A complete operational definition was not specified at the time of publication.
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This objective is adapted from Healthy People objective 13.15 (Oral Health).

See Appendix A for focus area contact information.



21-16. Increase the number of States and the District of Columbia that have an oral and craniofacial health surveillance system.

National Data Source	Association of State and Territorial Dental Directors (ASTDD).
State Data Source	Statewide oral health surveys; Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP; Water Fluoridation Reporting System (WFRS), CDC, NCCDPHP; Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP; Pregnancy risk data; State cancer registries/Surveillance, Epidemiology, and End Results (SEER), NIH, NCI; Orofacial cleft data; Medicaid dental claims data, HCFA; Annual synopsis of State dental programs, Association of State and Territorial Dental Directors (ASTDD).
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	0 (1999).
Numerator	Number of States or the District of Columbia with surveillance data for at least six of the nine possible surveillance databases listed above.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Appendix A for focus area contact information.



21-17. (Developmental) Increase the number of Tribal, State (including the District of Columbia), and local health agencies that serve jurisdictions of 250,000 or more persons that have in place an effective public dental health program directed by a dental professional with public health training.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Association of State and Territorial Dental Directors; the Annual Synopsis of State Dental Programs (ASTDD); and the Indian Health Service (IHS).

See Appendix A for focus area contact information.



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4. Krauss, N.A.; Machlin, S.; and Kass, B.L. Use of health care services, 1996. *MEPS Research Findings*, No. 7. AHCPR Pub. No.99-0018. Rockville, MD: Agency for Health Care Policy and Research, 1998.

22

Physical Activity and Fitness

Physical Activity in Adults

- 22-1 No leisure-time physical activity
- 22-2 Moderate physical activity
- 22-3 Vigorous physical activity

Muscular Strength/Endurance and Flexibility

- 22-4 Muscular strength and endurance
- 22-5 Flexibility

Physical Activity in Children and Adolescents

- 22-6 Moderate physical activity in adolescents
- 22-7 Vigorous physical activity in adolescents
- 22-8 Physical education requirement in schools
 - 22-8a Middle and junior high schools
 - 22-8b Senior high schools
- 22-9 Daily physical education in schools
- 22-10 Physical activity in physical education class
- 22-11 Television viewing

Access

- 22-12 School physical activity facilities
- 22-13 Worksite physical activity and fitness
- 22-14 Community walking
 - 22-14a Adults aged 18 years and older
 - 22-14b Children and adolescents aged 5 to 15 years
- 22-15 Community bicycling
 - 22-15a Adults aged 18 years and older
 - 22-15b Children and adolescents aged 5 to 15 years

Physical Activity in Adults

22-1. Reduce the proportion of adults who engage in no leisure-time physical activity.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 1.5 (Physical Activity and Fitness).
Measure	Percent (age adjusted—see Comments).
Baseline	40 (1997).
Numerator	Number of adults aged 18 years and older who report that they never or are unable to do light or moderate physical activity for at least 20 minutes (at least 10 minutes after 1997) and that they never or are unable to do vigorous physical activity for at least 20 minutes (at least 10 minutes after 1997).
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Health Interview Survey:</p> <ul style="list-style-type: none">➤ <i>How often do you do VIGOROUS activities for AT LEAST 10 MINUTES that cause HEAVY sweating or LARGE increases in breathing or heart rate?</i> <i>Never</i> <i>Unable to do this type activity</i> _____ <i>times per day/week/month/year</i><ul style="list-style-type: none">○ <i>About how long do you do these vigorous activities each time?</i> _____ <i>minutes/hours</i>➤ <i>How often do you do LIGHT OR MODERATE activities for AT LEAST 10 MINUTES that cause ONLY LIGHT sweating or a SLIGHT TO MODERATE increase in breathing or heart rate?</i> <i>Never</i> <i>Unable to do this type activity</i> _____ <i>times per day/week/month/year</i>

- *About how long do you do these light or moderate activities each time?*

_____ minutes/hours

Expected Periodicity

Annual.

Comments

Adults are classified as not engaging in leisure time physical activity if they answer “never” or “Unable to do this type of activity” to both the vigorous and moderate physical activity questions. Responses of “over 28 times per week” to either vigorous or moderate or both sets of questions were eliminated from the Denominator.

Although the 1997 baseline reflects responses of “never” or “unable [to do physical activities] for at least 20 minutes,” the question has been changed. Future updates for this objective will use a smaller time reference of 10 minutes. Estimates are expected to decline slightly.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

National and State estimates are not comparable; the questions are different. Also, the national survey is administered by personal interview, and the State survey is administered by telephone. Neither survey accounts for people who report no leisure-time physical activity who may not necessarily have a sedentary lifestyle; their jobs may require regular or vigorous physical activity that is not reported in response to these questions.

This objective is measured differently from the Healthy People 2000 objective. A discussion on measuring objective 1.5 can be found in Healthy People 2000 Statistical Notes.¹

See Part C for descriptions of NHIS and BRFSS and Appendix A for focus area contact information.



22-2. Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 1.3 (Physical Activity and Fitness) (also 15.11 and 17.13).
Leading Health Indicator	Physical Activity.
Measure	Percent (age adjusted—see Comments).
Baseline	15 (1997).
Numerator	Number of adults aged 18 years and older who report light or moderate physical activity for at least 30 minutes five or more times per week.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Health Interview Survey:</p> <p>➤ <i>How often do you do LIGHT OR MODERATE activities for AT LEAST 10 MINUTES that cause ONLY LIGHT sweating or a SLIGHT TO MODERATE increase in breathing or heart rate?</i></p> <p><i>Never</i> <i>Unable to do this type activity</i> _____ <i>times per day/week/month/year</i></p> <p>○ <i>About how long do you do these light or moderate activities each time?</i> _____ <i>minutes/hours</i></p>
Expected Periodicity	Annual.
Comments	<p>Adults are classified as participating in light or moderate physical activity if they answer 5 to 28 times per week and 30 to 720 minutes for each time.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p>

Current national and State estimates are not comparable; the questions are different. Also, the national survey is administered by personal interview, and the State survey is administered by telephone. Neither survey accounts for people whose jobs may require regular or vigorous physical activity that is not reported in response to these questions.

This objective is measured differently from the Healthy People 2000 objective; the new questions generally produce smaller estimates of moderate physical activity. A discussion on measuring objective 1.3 can be found in Healthy People 2000 Statistical Notes.¹

This objective is one of the measures used to track the Physical Activity Leading Health Indicator. See Appendix H for a complete listing.

See Part C for descriptions of NHIS and BRFSS and Appendix A for focus area contact information.



22-3. Increase the proportion of adults who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 1.4 (Physical Activity and Fitness).
Measure	Percent (age adjusted—see Comments).
Baseline	23 (1997).
Numerator	Number of adults aged 18 years and older who report participating in vigorous physical activity for at least 20 minutes three or more times per week.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.

**Questions Used To
Obtain the National
Data**

From the 1997 National Health Interview Survey:

- *How often do you do VIGOROUS activities for AT LEAST 10 MINUTES that cause HEAVY sweating or LARGE increases in breathing or heart rate?*

Never

Unable to do this type activity

_____ *times per day/week/month/year*

- *About how long do you do these vigorous activities each time?*

_____ *minutes/hours*

Expected Periodicity

Annual.

Comments

Adults are classified as participating in vigorous physical activity if they answer 3 to 28 times per week and 20 to 720 minutes for each time.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

Current national and State estimates are not comparable; the questions are different. Also, the national survey is administered by personal interview, and the State survey is administered by telephone. Neither survey accounts for people whose jobs may require regular or vigorous physical activity that is not reported in response to these questions.

This objective is measured differently from the Healthy People 2000 objective; the new questions generally produce larger estimates of vigorous physical activity. A discussion on measuring objective 1.4 can be found in Healthy People 2000 Statistical Notes.¹

See Part C for descriptions of NHIS and BRFSS and Appendix A for focus area contact information.



Muscular Strength/Endurance and Flexibility

22-4. Increase the proportion of adults who perform physical activities that enhance and maintain muscular strength and endurance.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 1.6 (Physical Activity and Fitness).
Measure	Percent (age adjusted—see Comments).
Baseline	18 (1998).
Numerator	Number of adults aged 18 years and older who report doing physical activities specifically designed to strengthen muscles at least twice a week.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>➤ <i>How often do you do physical activities specifically designed to STRENGTHEN your muscles such as lifting weights or doing calisthenics? (Include all such activities even if you have mentioned them before.)</i></p> <p><i>Never</i> <i>Unable to do this type activity</i> <i>_____ times per day/week/month/year</i></p>
Expected Periodicity	Annual.
Comments	<p>For this objective, adults were classified as doing strengthening activities if they responded that they did these activities 2 to 28 times per week.</p> <p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p> <p>State data do not come from a specific question about strengthening activities. Rather, the respondent is asked about participating in any physical activities or exercises and, if so, what type. These data are not comparable with national data.</p>

This objective is measured differently from the Healthy People 2000 objective. A discussion on measuring objective 1.6 can be found in Healthy People 2000 Statistical Notes.¹

See Part C for descriptions of NHIS and Appendix A for focus area contact information.



22-5. Increase the proportion of adults who perform physical activities that enhance and maintain flexibility.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 1.6 (Physical Activity and Fitness)
Measure	Percent (age adjusted—see Comments).
Baseline	30 (1998).
Numerator	Number of adults aged 18 years and older who report doing stretching exercises in the past 2 weeks.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>➤ <i>In the past 2 weeks, beginning Monday, (date), and ending this past Sunday, (date), have you done any of the following exercises, sports, or physically active hobbies...</i></p> <p>[Response categories include:]</p> <p><i>Stretching exercises?</i></p>
Expected Periodicity	Periodic.
Comments	<p>This objective is measured in the same way as the flexibility part of Healthy People 2000 objective 1.6. However, it differs from objective 1.6, which tracked ages 18 to 64 years only. A discussion of the measurement of objective 1.6 can be found in Healthy People 2000 Statistical Notes.¹</p>

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for descriptions of NHIS and Appendix A for focus area contact information.



Physical Activity in Children and Adolescents

22-6. Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days.

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 1.3 (Physical Activity and Fitness) (also 15.11 and 17.13).
Measure	Percent.
Baseline	27 (1999).
Numerator	Number of students in grades 9 through 12 who report participating for at least 30 minutes in physical activity that did not make them sweat or breathe hard on 5 or more of the 7 days preceding the survey.
Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used to Obtain the National Data	From the 1999 Youth Risk Behavior Surveillance System:

- *On how many of the past 7 days did you participate in physical activity for at least 30 minutes that did not make you sweat or breathe hard, such as fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors?*

0 days

1 day

2 days

3 days

4 days

5 days

6 days

7 days

Expected Periodicity

Biennial.

Comments

This objective differs from Healthy People 2000 objective 1.3, which tracked moderate physical activity in adults only.

See Part C for a description of YRBSS and Appendix A for focus area contact information.



22-7. Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.

National Data Source

Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

State Data Source

Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Healthy People 2000 Objective

Adapted from 1.4 (Physical Activity and Fitness).

Leading Health Indicator

Physical Activity.

Measure

Percent.

Baseline

65 (1999).

Numerator

Number of students in grades 9 through 12 who report exercising or participating for at least 20 minutes in physical activity that made them sweat and breathe hard on 3 or more of the 7 days preceding the survey.

Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	<p>From the 1999 Youth Risk Behavior Surveillance System:</p> <p>➤ <i>On how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities?</i></p> <p><i>0 days</i> <i>1 day</i> <i>2 days</i> <i>3 days</i> <i>4 days</i> <i>5 days</i> <i>6 days</i> <i>7 days</i></p>
Expected Periodicity	Biennial.
Comments	<p>This objective differs from Healthy People 2000 objective 1.4, which used different question wording. The former YRBSS question was: "On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes that made you sweat and breathe hard, such as basketball, jogging, swimming laps, tennis, fast bicycling, or similar aerobic activities?"</p> <p>This objective is one of the measures used to track the Physical Activity Leading Health Indicator. See Appendix H for a complete list.</p> <p>See Part C for a description of YRBSS and Appendix A for focus area contact information.</p>



22-8. Increase the proportion of the Nation's public and private schools that require daily physical education for all students.

22-8a. Middle and junior high schools.

National Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
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State Data Source	School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	17 (1994).
Numerator	Number of public and private middle and junior high schools for which physical education (PE) is offered 5 days a week, and the number of years of required PE equals the number of grades in the school.
Denominator	Number of public and private middle and junior high schools.
Population Targeted	Public and private middle and junior high schools.
Questions Used To Obtain the National Data	<p>From the 1994 School Health Policies and Programs Study Physical Education School Questionnaire:</p> <p>➤ <i>[Question 3] How much physical education are students required to take while attending this school? Please count all of a student's physical education requirements.</i></p> <p><i>Number of units required:</i></p> <p><i>Years</i> <i>Semesters</i> <i>Trimesters</i> <i>Quarters</i> <i>Weeks</i> <i>Carnegie units</i> <i>Other (SPECIFY UNIT):</i></p> <p>➤ <i>[Question 8] During required physical education courses, how many days per week do students attend class? CHECK THE ONE BEST ANSWER (1-7):</i></p> <p><i>(1) One day</i> <i>(2) Two days</i> <i>(3) Two days one week/ three days the next (alternating)</i> <i>(4) Three days</i> <i>(5) Four days</i> <i>(6) Five days</i> <i>(7) Differs by grade — GO ON TO NEXT QUESTION</i></p>

- [Question 9] How many days per week do students attend required physical education courses by grade in your school? CHECK BOX (1-7) AND RECORD NUMBER OF DAYS FOR EACH GRADE THAT TAKES REQUIRED PHYSICAL EDUCATION.

Days per week

- (1) 6th
- (2) 7th
- (3) 8th
- (4) 9th
- (5) 10th
- (6) 11th
- (7) 12th

Expected Periodicity

Periodic.

Comments

From question 3, the number of units (semesters, quarters, etc.) of PE that students were required to take while attending the particular school were standardized to years of required PE. If the number of years of required PE (from question 9) equaled the number of grades in that school (from another database), and if the response to question 8 was all 5 days, students were considered to be required to take PE 5 days a week for each year they attended that school.

See Part C for a description of SHPPS and Appendix A for focus area contact information.



22-8b. Senior high schools.

National Data Source

School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

State Data Source

School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

Healthy People 2000 Objective

Not applicable.

Measure

Percent.

Baseline

2 (1994).

Numerator

Number of public and private senior high schools for which physical education (PE) is offered 5 days a week, and the number of years of required PE equals the number of grades in the school.

Denominator	Number of public and private senior high schools.
Population Targeted	Public and private senior high schools.
Questions Used To Obtain the National Data	From the 1994 School Health Policies and Programs Study school physical education questionnaire: See Questions Used To Obtain the National Data provided with objective 22-8a.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 22-8a for more information.



22-9. Increase the proportion of adolescents who participate in daily school physical education.

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	1.8 (Physical Activity and Fitness).
Measure	Percent.
Baseline	29 (1999).
Numerator	Number of students in grades 9 through 12 who report participating in physical education classes five times per week.
Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	From the 1999 Youth Risk Behavior Surveillance System:

- *In an average week when you are in school, on how many days do you go to physical education (PE) classes?*

0 days

1 day

2 days

3 days

4 days

5 days

Expected Periodicity	Biennial.
Comments	See Part C for a description of YRBSS and Appendix A for focus area contact information.



22-10. Increase the proportion of adolescents who spend at least 50 percent of school physical education class time being physically active.

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	1.9 (Physical Activity and Fitness).
Measure	Percent.
Baseline	38 (1999).
Numerator	Number of students in grades 9 through 12 who report spending 21 or more minutes exercising or playing sports in physical education class three to five times a week.
Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	From the 1999 Youth Risk Behavior Surveillance System:

- *In an average week when you are in school, on how many days do you go to physical education (PE) classes?*
 - 0 days
 - 1 day
 - 2 days
 - 3 days
 - 4 days
 - 5 days
- *During an average physical education (PE) class, how many minutes do you spend actually exercising or playing sports?*
 - I do not take PE*
 - Less than 10 minutes*
 - 10 to 20 minutes*
 - 21 to 30 minutes*
 - More than 30 minutes*

Expected Periodicity	Biennial.
Comments	See Part C for a description of YRBSS and Appendix A for focus area contact information.



22-11. Increase the proportion of adolescents who view television 2 or fewer hours on a school day.

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	57 (1999).
Numerator	Number of students in grades 9 through 12 who report watching TV for 2 or fewer hours on an average school day.
Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	From the 1999 Youth Risk Behavior Surveillance System:

- *On an average school day, how many hours do you watch TV?*

I do not watch TV on an average school day

Less than 1 hour per day

1 hour per day

2 hours per day

3 hours per day

4 hours per day

5 or more hours per day

Expected Periodicity

Biennial.

Comments

Students who report that they did not watch TV on an average school day or watched TV less than 1 hour per day, 1 hour per day, or 2 hours per day were classified as viewing television for 2 or fewer hours during a school day.

See Part C for a description of YRBSS and Appendix A for focus area contact information.



Access

- 22-12. (Developmental) Increase the proportion of the Nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations).**

Comments

An operational definition could not be specified at the time of publication.

The expected national data source for this objective is the School Health Policies and Programs Study (SHPPS) Physical Education School Questionnaire, CDC, NCCDPHP, from which 2000 baseline data will be obtained.

The numerator will be the number of schools that allow children, adolescents, and adults who are not school employees to use any of the school's physical activity or athletic facilities outside of school hours or when school is not in session; the denominator will be the number of schools with indoor physical activity or athletic facilities.

The 2000 baseline data will be obtained by the following three questions:

- *Outside of school hours or when school is not in session, do children or adolescents use any of this school's physical activity or athletic facilities for...*
Community-sponsored sports teams?
Community-sponsored classes or lessons, such as tennis or gymnastics?
Community-sponsored supervised "open-gym" or "free play?"
- *Outside of school hours or when school is not in session, do adults who are not school employees use any of this school's physical activity or athletic facilities for...*
Community-sponsored sports teams?
Community-sponsored classes or lessons, such as tennis or aerobics?
Community-sponsored supervised "open-gym?"
- *Can children or adults in the community use this school's outdoor physical activity and athletic facilities without being in a supervised program?*

See Part C for a description of SHPPS and Appendix A for focus area contact information.



22-13. Increase the proportion of worksites offering employer-sponsored physical activity and fitness programs.

National Data Source	1999 National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP) and OPHS, ODPHP.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 1.10 (Physical Activity and Fitness).
Measure	Percent.
Baseline	46 (1998–99).
Numerator	Number of nongovernmental worksites with 50 or more employees offering employer-sponsored physical activity and fitness programs at the worksite or through their health plans.
Denominator	Number of nongovernmental worksites with 50 or more employees.

Population Targeted	Nongovernmental worksites with 50 or more employees.
Questions Used to Obtain the National Data	<p>From the 1999 National Worksite Health Promotion Survey:</p> <ul style="list-style-type: none"> ➤ <i>During the last 12 months, did you offer physical activity and/or fitness programs or activities to your employees at the worksite?</i> ➤ <i>During the last 12 months, did you offer physical activity and/or fitness programs or activities to your employees through one of your health plans?</i>
Expected Periodicity	Periodic.
Comments	<p>Worksites for which respondents answered “yes” to either question above were classified as offering employer-sponsored physical activity and fitness programs.</p> <p>This objective differs from Healthy People 2000 objective 1.10, which used different surveys, none of which asked about programs or activities through worksite health plans.</p> <p>See Part C for a description of NWHPS and Appendix A for focus area contact information.</p>



22-14. Increase the proportion of trips made by walking.

22-14a. Adults aged 18 years and older.

National Data Source	Nationwide Personal Transportation Survey (NPTS), DOT.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	17 (1995).
Numerator	Number of trips of 1 mile or less that adults aged 18 years and older report taking by walking on designated travel day.

Denominator	Number of trips of 1 mile or less that adults aged 18 years and older report taking on designated travel day.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used to Obtain the National Data	<p>From the 1995 Nationwide Personal Transportation Survey:</p> <p><i>Now I have some questions about all trips (you/<u>Person</u>) took (yesterday/on <u>Travel Day</u>), (including long trips that may have already been reported). For these questions, a "trip" is any time (you/<u>Person</u>) went from one address to another by car, bus, walking, bicycling, or some other means. For example, if you leave work, stop at the store, and then continue home that would be two trips—one to the store and one from the store to home.</i></p> <ul style="list-style-type: none"> ➤ <i>Did (you/<u>Person</u>) go anywhere (yesterday/on <u>Travel Day</u>)?</i> ➤ <i>(Excluding the trips taken as a regular part of the job), please tell me everywhere (you/<u>Person</u>) went (yesterday/on <u>Travel Day</u>). Remember, we want to know about any time (you/<u>Person</u>) went from one place to another for any purpose.</i> ➤ <i>Where did (you/<u>Person</u>) go first (yesterday/on <u>Travel Day</u>)?</i> ➤ <i>When (you/<u>Person</u>) left (<u>Destination</u>) where did (you/<u>Person</u>) go next?</i> <p>[Repeat question until no more trips....]</p> <p><i>Now I have a few questions about each trip.</i></p> <ul style="list-style-type: none"> ➤ <i>How far is it from where (you/<u>Person</u>) started to (<u>Destination</u>)? _____ miles</i> <p>[For nonsegmented trips:]</p> <ul style="list-style-type: none"> ➤ <i>How did (you/<u>Person</u>) get to (<u>Destination</u>)? That is, what means of transportation did (you/<u>Person</u>) use for this trip?</i> <p style="margin-left: 40px;">Walk Bicycle</p> <p>[For multisegment trips:]</p> <ul style="list-style-type: none"> ➤ <i>What means of transportation did (you/<u>Person</u>) use for the (first/next) part of this trip to (<u>Destination</u>)?</i> <p style="margin-left: 40px;">Walk Bicycle</p> <p>[Continue for additional segments...]</p>
Expected Periodicity	Periodic.
Comments	The 1995 NPTS sample design provided a scientific

sample of households with telephones in the United States, covering all 50 States and the District of Columbia. The sample was stratified by geography and time so that the data collection would be dispersed nearly uniformly throughout the country and across the data collection period. The sampling was also controlled by day of the week to capture variations in personal travel within a week. A Mitofsky-Waksberg random-digit-dialing design was used to select the sample telephone numbers, both listed and unlisted. The population of interest was defined as all persons aged 5 years and older.

Demographic data for each household member included age, sex, and race of the household reference person (person who owned or rented the home) and the relationship of each household member to the reference person, annual combined household income, and education.

The travel day was defined as beginning at 4:00 a.m. on the designated day and ending at 3:59 a.m. on the following day. In Quarter 1, a primary number was randomly assigned to each day of the week—one-seventh to each day. All households identified in the cluster associated with the primary number were assigned the same travel day. In Quarters 2, 3, and 4, every sample telephone number was randomly assigned a day of the week so that about one-seventh were assigned to each day. In general, telephone numbers were called the day after their assigned travel day.

Data for adults are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

The age groups used to age adjust the NPTS estimates are 18 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 to 74 years, 75 to 84 years, and 85 years and older.

This objective is similar to Healthy People 2010 objective 8-2b; however, objective 8-2b does not specify distance, age, or purpose of trip.

See Appendix A for focus area contact information.



22-14b. Children and adolescents aged 5 to 15 years.

National Data Source	Nationwide Personal Transportation Survey (NPTS), DOT.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	31 (1995).
Numerator	Number of trips to school of 1 mile or less that children and adolescents aged 5 to 15 years report taking by walking on designated travel day.
Denominator	Number of trips to school of 1 mile or less that children and adolescents aged 5 to 15 years report taking on designated travel day.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1995 Nationwide Personal Transportation Survey:

Now I have some questions about all trips (you/Person) took (yesterday/on Travel Day), (including long trips that may have already been reported). For these questions, a "trip" is any time (you/Person) went from one address to another by car, bus, walking, bicycling, or some other means. For example, if you leave work, stop at the store, and then continue home that would be two trips C one to the store and one from the store to home.

- *Did (you/Person) go anywhere (yesterday/on Travel Day)?*
- *(Excluding the trips taken as a regular part of the job), please tell me everywhere (you/Person) went (yesterday/on Travel Day). Remember, we want to know about any time (you/Person) went from one place to another for any purpose.*
- *Where did (you/Person) go first (yesterday/on Travel Day)?*
- *When (you/Person) left (Destination) where did (you/Person) go next?*

[Repeat question until no more trips....]

Now I have a few questions about each trip.

- *What was the main purpose of the trip to (Destination)?*

School/church

- *How far is it from where (you/Person) started to (Destination)?*

_____miles

[For nonsegmented trips:]

- *How did (you/Person) get to (Destination)? That is, what means of transportation did (you/Person) use for this trip?*

Walk

Bicycle

[For multisegment trips:]

- *What means of transportation did (you/Person) use for the (first/next) part of this trip to (Destination)?*

Walk

Bicycle

[Continue for additional segments...]

Expected Periodicity

Periodic.

Comments

See Comments provided with objective 22-14a for more information.



22-15. Increase the proportion of trips made by bicycling.

22-15a. Adults aged 18 years and older.

National Data Source

Nationwide Personal Transportation Survey (NPTS), DOT.

State Data Source

Not identified.

Healthy People 2000 Objective

Not applicable.

Measure

Percent.

Baseline

0.6 (1995).

Numerator

Number of trips of 5 miles or less that adults aged 18 years and older report taking by bicycling on designated travel day.

Denominator	Number of trips of 5 miles or less that adults aged 18 years and older report taking on designated travel day.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 22-14a.
Expected Periodicity	Periodic.
Comments	<p>See Comments provided with objective 22-14a for more information.</p> <p>This objective is similar to Healthy People 2010 objective 8-2a; however, objective 8-2a does not specify distance, age, or purpose of trip.</p> <p>See Appendix A for focus area contact information.</p>



22-15b. Children and adolescents aged 5 to 15 years.

National Data Source	Nationwide Personal Transportation Survey (NPTS), DOT.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	2.4 (1995).
Numerator	Number of trips to school of 2 miles or less that children and adolescents aged 5 to 15 years report taking by bicycle on designated travel day.
Denominator	Number of trips to school of 2 miles or less that children and adolescents aged 5 to 15 years report taking on designated travel day.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 22-14b.
Expected Periodicity	Periodic.

Comments

See Comments provided with objectives 22-14a and 22-15a for more information.



Reference

1. Chong, Y.; Klein, R.; Plepys, C.; et al. Operational definitions for year 2000 objectives: Priority area 1, Physical Activity and Fitness. *Healthy People 2000 Statistical Notes*, No. 18. Hyattsville, MD: National Center for Health Statistics, 1998.

23

Public Health Infrastructure

Data and Information Systems

- 23-1 Public health employee access to the Internet
- 23-2 Public health access to information and surveillance data
- 23-3 Use of geocoding in health data systems
- 23-4 Data for all population groups
- 23-5 Data for Leading Health Indicators, Health Status Indicators, and Priority Data Needs at Tribal, State, and local levels
- 23-6 National tracking of Healthy People 2010 objectives
- 23-7 Timely release of data on objectives

Workforce

- 23-8 Competencies for public health workers
- 23-9 Training in essential public health services
- 23-10 Continuing education and training by public health agencies

Public Health Organizations

- 23-11 Performance standards for essential public health services
- 23-12 Health improvement plans
 - 23-12a Tribes
 - 23-12b States and the District of Columbia
 - 23-12c Local jurisdictions
- 23-13 Access to public health laboratory services
- 23-14 Access to epidemiology services
- 23-15 Model statutes related to essential public health services

Resources

23-16 Data on public health expenditures

Prevention Research

23-17 Population-based prevention research

Data and Information Systems

- 23-1. (Developmental) Increase the proportion of Tribal, State, and local public health agencies that provide Internet and e-mail access for at least 75 percent of their employees and that teach employees to use the Internet and other electronic information systems to apply data and information to public health practice.**

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the National Public Health Performance Standards Program, CDC, PHPPO; the Indian Health Service (IHS) for Tribes; the Association of State and Territorial Health Officials (ASTHO) for States; and the National Association of County and City Health Officials (NACCHO) for local public health agencies.

See Appendix A for focus area contact information.



- 23-2. (Developmental) Increase the proportion of Federal, Tribal, State, and local health agencies that have made information available to the public in the past year on the Leading Health Indicators, Health Status Indicators, and Priority Data Needs.**

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the National Public Health Performance Standards Program, CDC, PHPPO; CDC, National Center for Health Statistics (NCHS) for Federal agencies; the Indian Health Service (IHS) for Tribes; the Association of State and Territorial Health Officials (ASTHO) for States; and the National Association of County and City Health Officials (NACCHO) for local public health agencies.

See Appendix A for focus area contact information.

23-3. Increase the proportion of all major national, State, and local health data systems that use geocoding to promote nationwide use of geographic information systems (GIS) at all levels.

National Data Source	National Center for Health Statistics (NCHS), CDC.
State Data Source	Not applicable.
Healthy People 2000 objective	Not applicable.
Measure	Percent.
Baseline	45 (2000).
Numerator	Number of major national, State, and local health data systems that collect street address or latitude and longitude information to enable geocoding analysis.
Denominator	Number of major national, State, and local health data systems.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A major health data system is one that is being used to track five or more Healthy People 2010 objectives. These data systems are listed in Part C of this volume.</p> <p>See Appendix A for focus area contact information.</p>



23-4. Increase the proportion of population-based Healthy People 2010 objectives for which national data are available for all population groups identified for the objective.

National Data Source	National Center for Health Statistics (NCHS), CDC.
State Data Source	Not applicable.
Healthy People 2000 objective	Not applicable.

Measure	Percent.
Baseline	11 (2000).
Numerator	Number of Healthy People 2010 population-based objectives or lettered subobjectives that have baselines for which national data are available for all population groups identified for the objective.
Denominator	Number of Healthy People 2010 population-based objectives or lettered subobjectives that have baselines.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Both objectives and lettered subobjectives that target the U.S. population are considered for this objective. In addition to the baselines for all persons targeted by the measure, Healthy People 2010 population-based measures are required to show a minimum set of sociodemographic population groups called a template (see General Data Issues, section 4).</p> <p>There were 432 population-based objectives and/or lettered subobjectives that had baselines (and are, thus, measurable) in the Conference Edition of Healthy People 2010. Forty-eight had complete templates, and 103 had no template displayed. Among those objectives with no template displayed, did not qualify for a template because the measures were raw numbers, not rates or percents. Thus, the denominator for the baseline was 409.</p> <p>The remaining objectives with templates had some incomplete data cells that were designated “DSU” (data statistically unreliable), “DNA” (data not analyzed), or “DNC” (data not collected).</p> <p>See Appendix A for focus area contact information.</p>



23-5. (Developmental) Increase the proportion of Leading Health Indicators, Health Status Indicators, and Priority Data Needs for which data—especially for select populations—are available at the Tribal, State, and local levels.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the National Center for Health Statistics (NCHS), CDC, for States and localities, and the Indian Health Service (IHS) for Tribes.

See Appendix A for focus area contact information.



23-6. Increase the proportion of Healthy People 2010 objectives that are tracked regularly at the national level.

National Data Source	National Center for Health Statistics (NCHS), CDC.
State Data Source	Not applicable.
Healthy People 2000 objective	Not applicable.
Measure	Percent.
Baseline	82 (2000).
Numerator	Number of Healthy People 2010 objectives or lettered subobjectives that have baselines and are tracked nationally at least every 3 years.
Denominator	Number of Healthy People 2010 objectives and lettered subobjectives that have baselines.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

The Healthy People 2010 objectives and lettered subobjectives that are measurable (have baselines) are used to obtain the data for this objective. There were 579 measurable objectives and lettered subobjectives in the Conference Edition of Healthy People 2010, of which 474 are tracked with data systems that collect data at least every 3 years; 383 are tracked annually.

See Appendix A for focus area contact information.

**23-7. Increase the proportion of Healthy People 2010 objectives for which national data are released within 1 year of the end of data collection.**

National Data Source	National Center for Health Statistics (NCHS), CDC.
State Data Source	Not applicable.
Healthy People 2000 objective	Adapted from 22.7 (Surveillance and Data Systems).
Measure	Percent.
Baseline	36 (2000).
Numerator	Number of Healthy People 2010 objectives and lettered subobjectives tracked with major health data systems that release data within 1 year after the end of data collection.
Denominator	Number of Healthy People 2010 objectives and lettered subobjectives that are tracked by major health data systems.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

Major health data systems are defined as data systems that are used to track five or more Healthy People 2010 objectives (see Part C for a descriptive list of these systems). In the Conference Edition of Healthy People 2010, major data systems provided baselines for 338 objectives and lettered subobjectives. Of these 338, 123 were provided data by major health data systems that release data within 1 year of data collection.

This objective differs from Healthy People 2000 objective 22.7, which tracked all objectives instead of those tracked by major health data systems and did not take into consideration the periodicity of the data source.¹

See Appendix A for focus area contact information.



Workforce

23-8. (Developmental) Increase the proportion of Federal, Tribal, State, and local agencies that incorporate specific competencies in the essential public health services into personnel systems.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Health Services and Resources Administration (HRSA) for Federal agencies; the Indian Health Service (IHS) for Tribes; the Association of State and Territorial Health Officials (ASTHO) for States; and the National Association of County and City Health Officials (NACCHO) for local agencies.

See Appendix A for focus area contact information.



23-9. (Developmental) Increase the proportion of schools for public health workers that integrate into their curricula specific content to develop competency in the essential public health services.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Association of Schools of Public Health (ASPH); the American Association of Medical Colleges; the Bureau of Health Professions, HRSA; and the American Association of Colleges of Nursing.

See Appendix A for focus area contact information.



23-10. (Developmental) Increase the proportion of Federal, Tribal, State, and local public health agencies that provide continuing education to develop competency in essential public health services for their employees.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Department of Health and Human Services (HHS) for Federal agencies; the Indian Health Service (IHS) for Tribes; the Association of State and Territorial Health Officials (ASTHO) for States; and the National Association of County and City Health Officials (NACCHO) for local agencies.

See Appendix A for focus area contact information.



Public Health Organizations

23-11. (Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the National Public Health Performance Standards Program, CDC, PHPPO.

See Appendix A for focus area contact information.



23-12. Increase the proportion of Tribes, States, and the District of Columbia that have a health improvement plan and increase the proportion of local jurisdictions that have a health improvement plan linked with their State plan.

23-12a. (Developmental) Tribes.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the Indian Health Service (IHS).

See Appendix A for focus area contact information.



23-12b. States and the District of Columbia.

National Data Source	Association of State and Territorial Health Officials (ASTHO).
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State Data Source	Association of State and Territorial Health Officials (ASTHO).
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Healthy People 2000 objective	Not applicable.
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Measure	Percent.
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Baseline	78 (1997).
Numerator	Number of States, including the District of Columbia, with a health improvement plan.
Denominator	50 States and the District of Columbia.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	<p>The baseline refers to the number of States including the District of Columbia that developed objectives for the year 2000. This definition is a proxy for health improvement plans, and will change with subsequent updates.</p> <p>See Appendix A for focus area contact information.</p>



23-12c. Local jurisdictions.

National Data Source	National Profile of Local Health Departments (NPLHD), NACCHO.
State Data Source	National Profile of Local Health Departments (NPLHD), NACCHO.
Local Area Data Source	National Profile of Local Health Departments (NPLHD), NACCHO.
Healthy People 2000 objective	Not applicable.
Measure	Percent.
Baseline	32 (1992–93).
Numerator	Number of local jurisdictions with a health improvement plan linked with their State plan.
Denominator	Number of local jurisdictions.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.

Comments

The baseline reflects the proportion of local health departments that developed objectives for the year 2000. This definition is a proxy for health improvement plans and will change with subsequent updates.

See Part C for a description of NPLHD and Appendix A for focus area contact information.



23-13. (Developmental) Increase the proportion of Tribal, State, and local health agencies that provide or ensure comprehensive laboratory services to support essential public health services.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are CDC and the Association of Public Health Laboratories; the Association of State and Territorial Health Officials (ASTHO) for States; and the National Association of County and City Health Officials (NACCHO) for local health agencies.

See Appendix A for focus area contact information.



23-14. (Developmental) Increase the proportion of Tribal, State, and local public health agencies that provide or ensure comprehensive epidemiology services to support the essential public health services.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Council of State and Territorial Epidemiologists (CSTE) for State and local jurisdictions and the Indian Health Service (IHS) for Tribes.

See Appendix A for focus area contact information.



23-15. (Developmental) Increase the proportion of Federal, Tribal, State, and local jurisdictions that review and evaluate the extent to which their statutes, ordinances, and bylaws ensure the delivery of essential public health services.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Indian Health Service (IHS) for Tribes; the National Conference of State Legislators (NCSL) and the Association of State and Territorial Health Officials (ASTHO) for States; and the National Association of County and City Health Officials (NACCHO) for local jurisdictions.

See Appendix A for focus area contact information.



Resources

23-16. (Developmental) Increase the proportion of Federal, Tribal, State, and local public health agencies that gather accurate data on public health expenditures, categorized by essential public health service.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Operating Divisions of the Department of Health and Human Services (HHS) for Federal agencies; the Indian Health Service (IHS) for Tribes; the Association of State and Territorial Health Officials (ASTHO) for States; and the National Association of County and City Health Officials (NACCHO) for local public health agencies.

See Appendix A for focus area contact information.



23-17. (Developmental) Increase the proportion of Federal, Tribal, State, and local public health agencies that conduct or collaborate on population-based prevention research.

Comments

An operational definition could not be specified at the time of publication.

Proposed data sources are the Association of Schools of Public Health (ASPH); the CDC Sentinel Network; the Association of State and Territorial Health Officials (ASTHO) for States; and the National Association of County and City Health Officials (NACCHO) for local public health agencies.

See Appendix A for focus area contact information.



Reference

1. National Center for Health Statistics. *Healthy People 2000 Review, 1998–99*. Hyattsville, MD: Public Health Service, 1999.

24

Respiratory Diseases

Asthma

- 24-1 Deaths from asthma
 - 24-1a Children under age 5 years
 - 24-1b Children aged 5 to 14 years
 - 24-1c Adolescents and adults aged 15 to 34 years
 - 24-1d Adults aged 35 to 64 years
 - 24-1e Adults aged 65 years and older
- 24-2 Hospitalizations for asthma
 - 24-2a Children under age 5 years
 - 24-2b Children and adults age 5 to 64 years
 - 24-2c Adults aged 65 years and older
- 24-3 Hospital emergency department visits for asthma
 - 24-3a Children under age 5 years
 - 24-3b Children and adults aged 5 to 64 years
 - 24-3c Adults aged 65 years and older
- 24-4 Activity limitations
- 24-5 School or work days lost
- 24-6 Patient education
- 24-7 Appropriate asthma care
 - 24-7a Written asthma management plans
 - 24-7b Persons with prescribed inhalers who receive instruction
 - 24-7c Education about recognizing early signs and symptoms of asthma episodes and how to respond appropriately
 - 24-7d Medication regimens that prevent the need for more than one canister of short-acting beta agonists per month
 - 24-7e Followup medical care for long-term management
 - 24-7f Assistance with assessing and reducing exposure to environmental risk factors
- 24-8 Surveillance systems

Chronic Obstructive Pulmonary Disease (COPD)

24-9 Activity limitations due to chronic lung and breathing problems

24-10 Deaths from COPD

Obstructive Sleep Apnea (OSA)

24-11 Medical evaluation and followup

24-11a Seek medical evaluation

24-11b Receive followup care

24-12 Vehicular crashes related to excessive sleepiness

Asthma

24-1. Reduce asthma deaths.

24-1a. Children under age 5 years.

National Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000,000 population.
Baseline	2.1 (1998).
Numerator	Number of asthma deaths (ICD-9 code 493) among children under age 5 years.
Denominator	Number of children under age 5 years.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



24-1b. Children aged 5 to 14 years.

National Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000,000 population.
Baseline	3.3 (1998).

Numerator	Number of asthma deaths (ICD-9 code 493) among children aged 5 to 14 years.
Denominator	Number of children aged 5 to 14 years.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



24-1c. Adolescents and adults aged 15 to 34 years.

National Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000,000 population.
Baseline	5.0 (1998).
Numerator	Number of asthma deaths (ICD-9 code 493) among adolescents and adults aged 15 to 34 years.
Denominator	Number of adolescents and adults aged 15 to 34 years.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



24-1d. Adults aged 35 to 64 years.

National Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000,000 population.
Baseline	17.8 (1998).
Numerator	Number of asthma deaths (ICD-9 code 493) among adults aged 35 to 64 years.
Denominator	Number of adults aged 35 to 64 years.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.

**24-1e. Adults aged 65 years and older.**

National Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000,000 population.
Baseline	86.3 (1998).
Numerator	Number of asthma deaths (ICD-9 code 493) among adults aged 65 years and older.
Denominator	Number of adults aged 65 years and older.
Population Targeted	U.S. resident population.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	See Part C for a description of NVSS and Appendix A for focus area contact information.



24-2. Reduce hospitalizations for asthma.

24-2a. Children under age 5 years.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge data systems.
Healthy People 2000 Objective	Adapted from 11.1 (Environmental Health).
Measure	Rate per 10,000 population.
Baseline	45.6 (1998).
Numerator	Number of discharges with principal diagnosis of asthma (ICD-9-CM code 493) among children under age 5 years.
Denominator	Number of children under age 5 years.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	From the 1998 National Hospital Discharge Survey: <ul style="list-style-type: none"> ➤ <i>Final Diagnoses (Including E-code diagnoses)</i> Principal: _____
Expected Periodicity	Annual.
Comments	Principal diagnosis is the diagnosis chiefly responsible for admission of the person to the hospital. This objective differs from Healthy People 2000 objective 11.1 in that different age breakouts are specified.

See Part C for a description of NHDS and Appendix A for focus area contact information.



24-2b. Children and adults aged 5 to 64 years.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge data systems.
Healthy People 2000 Objective	Adapted from 11.1 (Environmental Health).
Measure	Rate per 10,000 population (age adjusted—see Comments).
Baseline	12.5 (1998).
Numerator	Number of discharges with first listed diagnosis of asthma (ICD-9-CM code 493) among children and adults aged 5 to 64 years.
Denominator	Number of children and adults aged 5 to 64 years.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 24-2a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 24-2a for more information. Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.



24-2c. Adults aged 65 years and older.

National Data Source	National Hospital Discharge Survey (NHDS), CDC, NCHS.
State Data Source	State hospital discharge data systems.

Healthy People 2000 Objective	Adapted from 11.1 (Environmental Health).
Measure	Rate per 10,000 population (age adjusted—see Comments).
Baseline	17.7 (1998).
Numerator	Number of discharges with first listed diagnosis of asthma (ICD-9-CM code 493) among adults aged 65 years and older.
Denominator	Number of adults aged 65 years and older.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 24-2a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 24-2b for more information.



24-3. Reduce hospital emergency department visits for asthma.

24-3a. Children under age 5 years.

National Data Source	National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 10,000 population.
Baseline	150.0 (1995–97).
Numerator	Number of visits to an emergency department with first listed diagnosis of asthma (ICD-9-CM code 493) among children under age 5 years.
Denominator	Number of children under age 5 years.
Population Targeted	U.S. civilian, noninstitutionalized population.

Questions Used To Obtain the National Data	From the 1997–98 National Hospital Ambulatory Medical Care Survey: ➤ <i>Physician's diagnosis for the visit</i> <i>Primary diagnosis</i> _____
Expected Periodicity	Annual
Comments	See Part C for a description of NHAMCS and Appendix A for focus area contact information.



24-3b. Children and adults aged 5 to 64 years.

National Data Source	National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 10,000 population.
Baseline	71.1 (1995–97).
Numerator	Number of visits to an emergency department with first listed diagnosis of asthma (ICD-9-CM code 493) among children and adults aged 5 to 64 years.
Denominator	Number of children and adults aged 5 to 64 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 24-3a.
Expected Periodicity	Annual.
Comments	See Part C for a description of NHAMCS and Appendix A for focus area contact information.



24-3c. Adults aged 65 years and older.

National Data Source	National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
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State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 10,000.
Baseline	29.5 (1995–97).
Numerator	Number of visits to an emergency department with first listed diagnosis of asthma (ICD-9-CM code 493) among adults aged 65 years and older.
Denominator	Number of adults aged 65 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 24-3a.
Expected Periodicity	Annual.
Comments	See Part C for a description on NHAMCS and Appendix A for focus area contact information.



24-4. Reduce activity limitations among persons with asthma.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	17.4 (Diabetes and Chronic Disabling Conditions), age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	20 (1994–96).
Numerator	Number of persons who report having asthma and activity limitation in the past year.
Denominator	Number of persons who report having asthma.
Population Targeted	U.S. civilian, noninstitutionalized population
Questions Used To Obtain the National Data	From the 1996 National Health Interview Survey:

[NUMERATOR:]

- *Does any impairment or health problem now keep (name) from working at a job or business (or play/school for children under 18 years)?*
- *Is (name) limited in the kind or amount of work (name) can do because of any impairment or health problem?*
- *Does any impairment or health problem now keep (name) from doing any housework at all?*
- *Is (name) limited in the kind or amount of housework (name) can do because of any impairment or health problem?*
- *Is (name) limited in anyway in any activities because of an impairment or health problem?*

[DENOMINATOR:]

- *During the past 12 months did anyone in the family (names) have asthma?*

Expected Periodicity

Annual.

Comments

Persons are classified as having an activity limitation if they responded “yes” to any of the questions listed above under Numerator. Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

Subsequent versions of the NHIS will use different questions on a periodic basis to provide data related to this objective.

See Part C for a description of NHIS and Appendix A for focus area contact information.



24-5. (Developmental) Reduce the number of school or work days missed by persons with asthma due to asthma.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the National Health Interview Survey (NHIS), CDC, NCHS.

See Part C for a description of NHIS and Appendix A for focus area contract information.



24-6. Increase the proportion of persons with asthma who receive formal patient education, including information about community and self-help resources, as an essential part of the management of their condition.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	17.14b (Diabetes and Chronic Disabling Conditions) age adjusted to the 2000 standard population.
Measure	Percent (age adjusted—see Comments).
Baseline	8.4 (1998).
Numerator	Number of persons aged 18 years and older who report having asthma and have ever taken a course or class on how to manage their asthma.
Denominator	Number of persons aged 18 years and older who report having asthma in the past year.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>[NUMERATOR:]</p> <p>➤ <i>Have you ever taken a course or class in how to manage your asthma yourself?</i></p> <p>[DENOMINATOR:]</p> <p>➤ <i>Have you ever been told by a doctor or other health professional that you had asthma?</i></p>
Expected Periodicity	Periodic.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NHIS and Appendix A for focus area contact information.</p>



24-7. (Developmental) Increase the proportion of persons with asthma who receive appropriate asthma care according to the NAEPP Guidelines.

24-7a. (Developmental) Persons with asthma who receive written asthma management plans from their health care provider.

Comments An operational definition could not be specified at the time of publication.

 A proposed data source is the National Health Interview Survey (NHIS), CDC, NCHS.

 See Part C for a description of NHIS and Appendix A for focus area contract information.



24-7b. (Developmental) Persons with asthma with prescribed inhalers who receive instruction on how to use the inhaler properly.

Comments See Comments provided with objective 24-7a for more information.



24-7c. (Developmental) Persons with asthma who receive education about recognizing the early signs and symptoms of asthma episodes and how to respond appropriately, including instruction on peak flow monitoring for those who use daily therapy.

Comments See Comments provided with objective 24-7a for more information.



24-7d. (Developmental) Persons with asthma who receive medication regimens that prevent the need for more than one canister of short-acting inhaled beta agonists per month for relief of symptoms.

Comments See Comments provided with objective 24-7a for more information.

24-7e. (Developmental) Persons who receive followup medical care for long-term management of asthma after any hospitalization due to asthma.

Comments See Comments provided with objective 24-7a for more information.



24-7f. (Developmental) Persons with asthma who receive assistance with assessing and reducing exposure to environmental risk factors in their home, school, and work environments.

Comments See Comments provided with objective 24-7a for more information.



24-8. (Developmental) Establish in at least 25 States a surveillance system for tracking asthma death, illness, disability, impact of occupational and environmental factors on asthma, access to medical care, and asthma management.

Comments An operational definition could not be specified at the time of publication.

Proposed data sources are periodic surveys by the Council of State and Territorial Epidemiologists and the Association of Schools of Public Health.

See Appendix A for focus area contact information.



Chronic Obstructive Pulmonary Disease (COPD)

24-9. Reduce the proportion of adults whose activity is limited due to chronic lung and breathing problems.

National Data Source National Health Interview Survey (NHIS), CDC, NCHS.

State Data Source Not identified.

Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	2.2 (1997).
Numerator	Number of adults aged 45 years and older who report activity limitation due to a chronic lung or breathing problem in the past year.
Denominator	Number of adults aged 45 years and older who report activity limitation in the past year.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997 National Health Interview Survey:

[NUMERATOR:]

- *What condition or health problem causes (Subject name's) limitation?*

[Response categories include:]

Lung/breathing problem

[If yes,]

- *How long have you had (lung/breathing problem)?*

[DENOMINATOR:]

- *I am now going to ask you about (your/the) general health (/of family members) and the effects of any physical, mental, or emotional health problems.*
- *Because of a physical, mental or emotional problem (do/does) (you/anyone) in the family need the help of other persons with PERSONAL CARE NEEDS, such as eating, bathing, dressing, or getting around inside this home?*
- *Because of a physical, mental or emotional problem (do/does) (you/anyone) in the family need the help of other persons in handling ROUTINE NEEDS, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?*
- *Does a physical, mental or emotional problem NOW keep (you/any family members aged 18 and older) from working at a job or business?*
- *(Are any of family members aged 18 and older) limited in the kind OR amount of work (you/they) can do because of a physical, mental or emotional problem?*

- *Because of a health problem, (do/does) (you/anyone) in the family have difficulty walking without using any special equipment?*
- *(Are/Is) (you/anyone) in the family LIMITED IN ANY WAY in any activities because of difficulty remembering or because (you/they) experience periods of confusion?*
- *(Are/Is) (you/anyone) in the family LIMITED IN ANY WAY in any activities because of physical, mental or emotional problems?*

Expected Periodicity

Periodic.

Comments

Adults aged 45 years and older are defined as being limited in activity due to a chronic lung or breathing problem if they respond “yes” to any of the limitation questions listed above in the Denominator section and report that the reason for the limitation is a chronic lung or breathing problem. An adult is considered to have a chronic lung/breathing problem if they report having the condition for 3 months or more.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and Appendix A for focus area contact information.



24-10. Reduce deaths from chronic obstructive pulmonary disease (COPD) among adults.

National Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics Systems (NVSS), CDC, NCHS.
Healthy People 2000 Objective	Adapted from 3.3 (Tobacco), age adjusted to the 2000 standard population.
Measure	Rate per 100,000 (age adjusted—see Comments).
Baseline	119.4 (1998).
Numerator	Number of COPD deaths (ICD-9 code 490-496) among adults aged 45 years and older.

Denominator	Number of adults aged 45 years and older.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>This objective is adapted from Healthy People 2000 objective 3.3 (Tobacco), which tracked COPD among persons of all ages and was age adjusted to the 1940 standard population. This measure tracks adults aged 45 years and older only and is age adjusted to the 2000 standard population. See Appendix C for comparison data. Age-adjusted rates are weighted sums of age-specific rates. For a discussion on age adjustment, see Part A, section 5.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



Obstructive Sleep Apnea (OSA)

24-11. (Developmental) Increase the proportion of persons with symptoms of obstructive sleep apnea whose condition is medically managed.

24-11a. (Developmental) Persons with excessive daytime sleepiness, loud snoring, and other signs associated with obstructive sleep apnea who seek medical evaluation.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed data source is the National Health Interview Survey (NHIS), CDC, NCHS.</p> <p>See Part C for a description of NHIS and Appendix A for focus area contact information.</p>
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24-11b. (Developmental) Persons with excessive daytime sleepiness, loud snoring, and other signs associated with obstructive sleep apnea, who receive followup medical care for long-term management of their condition.

Comments

See Comments provided with objective 24-11b for more information.



24-12. (Developmental) Reduce the proportion of vehicular crashes caused by persons with excessive sleepiness.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source for this objective is the National Health Interview Survey (NHIS), CDC, NCHS. A set of questions have been drafted for inclusion in a future NHIS.

Other proposed data sources are the Fatality Analysis Reporting System (FARS), DOT, NHTSA.

See Part C for a description of NHIS and Appendix A for focus area contact information.



25

Sexually Transmitted Diseases

Bacterial STD Illness and Disability

- 25-1 Chlamydia
 - 25-1a Females aged 15 to 24 years attending family planning clinics
 - 25-1b Females aged 15 to 24 years attending STD clinics
 - 25-1c Males aged 15 to 24 years attending STD clinics
- 25-2 Gonorrhea
- 25-3 Primary and secondary syphilis

Viral STD Illness and Disability

- 25-4 Genital herpes
- 25-5 Human papillomavirus infection

STD Complications Affecting Females

- 25-6 Pelvic inflammatory disease (PID)
- 25-7 Fertility problems
- 25-8 Heterosexually transmitted HIV infection in women

STD Complications Affecting the Fetus and Newborn

- 25-9 Congenital syphilis
- 25-10 Neonatal STDs

Personal Behaviors

- 25-11 Responsible adolescent sexual behavior
- 25-12 Responsible sexual behavior messages on television

Community Protection Infrastructure

- 25-13 Hepatitis B vaccine services in STD clinics
- 25-14 Screening in youth detention facilities and jails
- 25-15 Contracts to treat nonplan partners of STD patients

Personal Health Services

- 25-16 Annual screening for genital chlamydia
- 25-17 Screening of pregnant women
- 25-18 Compliance with recognized STD treatment standards
- 25-19 Provider referral services for sex partners

Bacterial STD Illness and Disability

25-1. Reduce the proportion of adolescents and young adults with *Chlamydia trachomatis* infections.

25-1a. Females aged 15 to 24 years attending family planning clinics.

National Data Source	STD Surveillance System (STDSS), CDC, NCHSTP.
State Data Sources	State and local Health Department STD Control Programs and Regional Infertility Prevention Programs.
Healthy People 2000 Objective	Adapted from 19.2 (Sexually Transmitted Diseases).
Measure	Percent.
Baseline	5.0 (1997).
Numerator	Number of positive tests among women aged 15 to 24 years who attended family planning clinics in the past 12 months.
Denominator	Number tests administered (unsatisfactory tests, indeterminate or inconclusive results, or inadequate specimens are excluded) among women aged 15 to 24 years who attended family planning clinics in the past 12 months.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A case definition for <i>Chlamydia trachomatis</i> is provided by CDC.¹</p> <p>Data are collected from Regional Infertility Prevention Program laboratory reports.</p>

This measure tracks only tests that are specific for *Chlamydia trachomatis* infection. The number of positive cases is based on test results from persons routinely screened. Routine screening is defined by each clinic. In some clinics, all patients are universally screened. In others, routine screening is done selectively based on clinical findings or behavioral risk factors.

A minimum of 500 valid test results by gender and subpopulation is recommended to derive reliable estimates for this measure. Some clinics may not collect all U.S. Census-defined race and/or ethnicity data categories.

Data for this measure are also included in the annual STD Surveillance Report.²

This measure is a modification of Healthy People 2000 objective 19.2, which tracked percent positivity in women under age 25 years who attended family planning clinics. This measure tracks percent positivity among women aged 15 to 24 years who attended family planning clinics.

See Part C for a description of STDSS and Appendix A for focus area contact information.



25-1b. Females aged 15 to 24 years attending STD clinics.

National Data Source	STD Surveillance System (STDSS), CDC, NCHSTP.
State Data Sources	State and local Health Department STD Control Programs and Regional Infertility Prevention Programs.
Healthy People 2000 Objective	Adapted from 19.2 (Sexually Transmitted Diseases).
Measure	Percent.
Baseline	12.2 (1997).
Numerator	Number of positive tests among women aged 15 to 24 years who attended STD clinics in the past 12 months.

Denominator	Number of tests administered (unsatisfactory tests, indeterminate or inconclusive results, or inadequate specimens are excluded) to women aged 15 to 24 years who attended STD clinics in the past 12 months.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A case definition for <i>Chlamydia trachomatis</i> is provided by CDC.¹</p> <p>Data are collected from Regional Infertility Prevention Program laboratory reports.</p> <p>This measure tracks only tests that are specific for <i>Chlamydia trachomatis</i> infection. The number of positive cases is based on test results from persons routinely screened. Routine screening is defined by each clinic. In some clinics, all patients are universally screened. In others, routine screening is done selectively based on clinical findings or behavioral risk factors.</p> <p>A minimum of 500 valid test results by gender and subpopulation is recommended to derive reliable estimates for this measure. Some clinics may not collect all U.S. Census-defined race and/or ethnicity data categories.</p> <p>Data for this measure are also included in the annual STD Surveillance Report.²</p> <p>This measure is a modification of Healthy People 2000 objective 19.2, which tracked percent positivity in women under age 25 years who attended family planning clinics. This measure expands upon the Healthy People 2000 measure and tracks percent positivity among women aged 15 to 24 years who attended STD clinics.</p> <p>See Part C for a description of STDSS and Appendix A for focus area contact information.</p>



25-1c. Males aged 15 to 24 years attending STD clinics.

National Data Source	STD Surveillance System (STDSS), CDC, NCHSTP.
State Data Source	State and local Health Department STD Control Programs.
Healthy People 2000 Objective	Adapted from 19.2 (Sexually Transmitted Diseases).
Measure	Percent.
Baseline	15.7 (1997).
Numerator	Number of positive tests among men aged 15 to 24 years who attended STD clinics in the past 12 months.
Denominator	Number tests administered (unsatisfactory tests, indeterminate or inconclusive results, or inadequate specimens are excluded) among men aged 15 to 24 years who attended STD clinics in the past 12 months.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A case definition for <i>Chlamydia trachomatis</i> is provided by CDC.¹</p> <p>Data are collected from Regional Infertility Prevention Program laboratory reports.</p> <p>This measure tracks only tests that are specific for <i>Chlamydia trachomatis</i> infection. The number of positive cases is based on test results from persons routinely screened. Routine screening is defined by each clinic. In some clinics, all patients are universally screened. In others, routine screening is done selectively based on clinical findings or behavioral risk factors.</p> <p>A minimum of 500 valid test results by gender and subpopulation is recommended to derive reliable estimates for this measure. Some clinics may not collect all U.S. Census-defined race and/or ethnicity data categories.</p>

Data for this measure are also included in the annual STD Surveillance Report.²

This measure is a modification of Healthy People 2000 objective 19.2, which tracked percent positivity in women under age 25 years who attended family planning clinics. This measure expands the Healthy People 2000 measure and tracks percent positivity among men aged 15 to 24 years who attended STD clinics.

See Part C for a description of STDSS and Appendix A for focus area contact information.



25-2. Reduce gonorrhea.

National Data Source	STD Surveillance System (STDSS), CDC, NCHSTP.
State Data Source	State and local Health Department STD Control Programs.
Healthy People 2000 Objective	19.1 (Sexually Transmitted Diseases).
Measure	Rate per 100,000 population.
Baseline	123 (1997).
Numerator	Number of new reported cases of gonorrhea in the past 12 months.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Report of Civilian Cases of Primary and Secondary Syphilis, Gonorrhea, and Chlamydia by Reporting Source, Sex, Race/Ethnicity, and Group, Form 73.2638, Rev. 01/96.
Expected Periodicity	Annual.
Comments	In most instances, if age or race/ethnicity was not specified, cases were allocated according to the distribution of cases for which these variables were specified. In 1998, New Jersey and Idaho did not report race/ethnicity for most cases and were excluded.

Data for this measure are also included in the annual STD Surveillance Report.²

See Part C for a description of STDSS and Appendix A for focus area contact information.



25-3. Eliminate sustained domestic transmission of primary and secondary syphilis.

National Data Source	STD Surveillance System (STDSS), CDC, NCHSTP.
State Data Source	State and local Health Department STD Control Programs.
Healthy People 2000 Objective	19.3 (Sexually Transmitted Diseases).
Measure	Rate per 100,000 population.
Baseline	3.2 (1997).
Numerator	Number of new reported cases of primary and secondary syphilis in the past 12 months.
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Report of Civilian Cases of Primary and Secondary Syphilis, Gonorrhea, and Chlamydia by Reporting Source, Sex, Race/Ethnicity, and Group, Form 73.2638, Rev. 01/96.
Expected Periodicity	Annual.
Comments	Data are collected using Form 2638 from CDC. In most instances, if age or race/ethnicity was not specified, cases were allocated according to the distribution of cases for which these variables were specified.

Data for this measure are also included in the annual STD Surveillance Report.²

See Part C for a description of STDSS and Appendix A for focus area contact information.



25-4. Reduce the proportion of adults with genital herpes infection.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 19.5 (Sexually Transmitted Diseases).
Measure	Percent.
Baseline	17 (1988–94).
Numerator	Number of adults aged 20 to 29 years with a positive result from a herpes simplex virus, type 2 (HSV-2) laboratory test.
Denominator	Number of adults aged 20 to 29 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual beginning with 1999 data.
Comments	<p>A case definition for genital herpes is provided by CDC.¹</p> <p>This measure is a modification of Healthy People 2000 objective 19.5, which tracked the number of first-time visits to physicians' offices for genital herpes, as measured by the National Disease and Therapeutic Index, IMS America, Ltd. This measure tracks the proportion of persons aged 20 to 29 years with a positive laboratory test result for herpes simplex virus, type 2, as measured by NHANES.</p> <p>See Part C for a description of NHANES and Appendix A for focus area contact information.</p>



25-5. (Developmental) Reduce the proportion of persons with human papillomavirus (HPV) infection.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>The proposed national data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS. A reduction in the number of HPV cases will minimize the prevalence of subtypes 16 and 18 and other subtypes associated with cervical cancer in persons aged 15 to 44 years.</p> <p>This objective is modified from Healthy People 2000 objective 19.5, which tracked the number of first-time consultations for genital warts.</p> <p>See Appendix A for focus area contact information.</p>
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STD Complications Affecting Females

25-6. Reduce the proportion of females who have ever required treatment for pelvic inflammatory disease (PID).

National Data Source	National Survey of Family Growth (NSFG), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 19.6 (Sexually Transmitted Diseases).
Measure	Percent.
Baseline	8 (1995).
Numerator	Number of females aged 15 to 44 years who reported ever requiring treatment for PID.
Denominator	Number of females aged 15 to 44 years.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	From the 1995 National Survey of Family Growth:

- *Have you ever been treated for an infection in your fallopian tubes, womb, or ovaries, also called a pelvic infection, pelvic inflammatory disease, or P.I.D.?*

Expected Periodicity

Periodic.

Comments

There are no reliable national surveillance systems that measure women requiring treatment for PID. This measure, based on data from NSFG, is used as a proxy for this objective.

PID is a subjective diagnosis made by physicians. Laparoscopy is required for a definitive diagnosis of PID. The data from the NSFG are self-reported and therefore may not be accurate, particularly due to the unknown prevalence of asymptomatic or subclinical PID.

This measure is a modification of Healthy People 2000 objective 19.6, which tracked the number of hospitalizations due to PID, as measured by the National Hospital Discharge Survey (NHDS), CDC, NCHS. This measure tracks the number of women aged 15 to 44 years who report ever requiring treatment for PID.

See Part C for a description of NSFG and Appendix A for focus area contact information.



25-7. Reduce the proportion of childless females with fertility problems who have had a sexually transmitted disease or who have required treatment for pelvic inflammatory disease (PID).

National Data Source

National Survey of Family Growth (NSFG), CDC, NCHS.

State Data Source

Not identified.

Healthy People 2000 Objective

Not applicable.

Measure

Percent.

Baseline

27 (1995).

Numerator

Number of childless females aged 15 to 44 years with fertility problems who report history of STD or PID.

Denominator	Number of females aged 15 to 44 years who are childless and have fertility problems.
Population Targeted	U.S. civilian population.
Questions Used To Obtain the National Data	<p>From the 1995 National Survey of Family Growth:</p> <p>[NUMERATOR:]</p> <ul style="list-style-type: none"> ➤ <i>Has a doctor or other medical care provider ever told you that you had:</i> <ul style="list-style-type: none"> <i>genital warts?</i> <i>gonorrhea?</i> <i>syphilis?</i> <i>genital herpes?</i> ➤ <i>Have you ever been treated for an infection in your fallopian tubes, womb, or ovaries, also called a pelvic infection, pelvic inflammatory disease, or P.I.D.?</i> <p>[DENOMINATOR:]</p> <p>[Following a series of questions to ALL respondents that address pregnancy, contraceptive use and periods of no sexual activity:]</p> <ul style="list-style-type: none"> ➤ <i>Have you ever had <u>both</u> your tubes tied, cut, or removed? This procedure is often called a tubal ligation.</i> ➤ <i>Have you ever had a hysterectomy, that is, surgery to <u>remove</u> your uterus?</i> ➤ <i>Have you ever had <u>both</u> your ovaries removed?</i> ➤ <i>Have you ever had any <u>other</u> operation that makes it impossible for you to have another baby?</i> ➤ <i>As far as you know, are you completely sterile from this operation, that is, does it make it impossible for you to have a baby in the future?</i> ➤ <i>Has (<u>name of husband/partner</u>) ever had a vasectomy or any other operation that would make it impossible to father a baby in the future?</i> <p>[Nonsurgically sterile respondents are those who have not reported any operations for themselves, or if they are married or cohabiting, for their husbands/partners.]</p> <p>[For respondents who are nonsurgically sterile:]</p> <ul style="list-style-type: none"> ➤ <i>Some women are not <u>physically</u> able to have children. As far as you know, is it physically possible for you, yourself, to have a baby?</i> ➤ <i>What about (<u>name of husband/partner</u>)? As far as you know, is it <u>physically</u> impossible for him to father a baby in the future?</i>

[If it is physically possible:]

- *Some women are physically able to have a baby, but have difficulty getting pregnant or carrying a baby to term. As far as you know, would you, yourself, have any difficulty getting pregnant or carrying a baby to term?*
- *As far as you know, does (name of male partner) have any difficulty fathering a baby?*
- *At any time has a medical doctor ever advised you to never become pregnant (again)?*

Expected Periodicity

Periodic.

Comments

Women are classified as childless if they have not given birth to a child and have not had a sterilizing operation.

Fertility problems refer to the standard medical definitions of infertility (have not used contraception and have not become pregnant for 12 months or more) or impaired fecundity (women reporting no sterilizing operation and are classified as those who find it difficult or impossible to get pregnant or carry a baby to term).

Respondents are considered to have fertility problems if they report that neither they or their husband/partner has had a sterilizing operation or any one of the following:

(1) she and her husband/partner are nonsurgically sterile and it is physically impossible for her to get pregnant or carry a baby to term or for her husband to father a baby.

(2) it is physically difficult for her to get pregnant or carry a baby to term or for her husband/partner to father a baby.

(3) she has been advised by a doctor (for health reasons) not to become pregnant.

(4) she and her husband/partner have reported sexual activity without contraception for at least 12 consecutive months and have had no pregnancies in that time period.

See Part C for a description of NSFG and Appendix A for focus area contact information.



25-8. (Developmental) Reduce HIV infections in adolescent and young adult females aged 13 to 24 years that are associated with heterosexual contact.

Comments	An operational definition could not be specified at the time of publication. The proposed national data source is the HIV/AIDS Surveillance System, CDC, NCHSTP. See Appendix A for focus area contact information.
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STD Complications Affecting the Fetus and Newborn

25-9. Reduce congenital syphilis.

National Data Sources	STD Surveillance System (STDSS), CDC, NCHSTP; National Vital Statistics System (NVSS), CDC, NCHS.
State Data Sources	State and local Health Department STD Control Programs; State and Local Vital Statistics.
Healthy People 2000 Objective	19.4 (Sexually Transmitted Diseases).
Measure	Rate per 100,000 live births.
Baseline	27 (1997).
Numerator	Number of new reported cases of congenital syphilis in the past 12 months.
Denominator	Number of live births.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	CDC Congenital Syphilis (CS) Case Investigation and Report, Form 73.126, Rev. 09/91.
Expected Periodicity	Annual.
Comments	Less than 5 percent of cases have missing race/ethnicity data and were excluded from the baseline estimate. Data for this measure are also included in the annual STD Surveillance Report. ²

See Part C for a description of STDSS and Appendix A for focus area contact information.



25-10. (Developmental) Reduce neonatal consequences from maternal sexually transmitted diseases, including chlamydial pneumonia, gonococcal and chlamydial ophthalmia neonatorum, laryngeal papillomatosis (from human papillomavirus infection), neonatal herpes, and preterm birth and low birth weight associated with bacterial vaginosis.

Comments	An operational definition could not be specified at the time of publication. The proposed national data source is the STD Surveillance System (STDSS), CDC, NCHSTP. See Appendix A for focus area contact information.
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Personal Behaviors

25-11. Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 5.5 and 5.6 (Family Planning) (also 18.15 and 19.16).
Leading Health Indicator	Responsible Sexual Behavior.
Measure	Percent.
Baseline	85 (1999).

Numerator	Number of students in grades 9 through 12 who report that they have never had sexual intercourse; or who have had sexual intercourse, but not in the past 3 months; or who have had sexual intercourse in the past 3 months but used a condom at last sexual intercourse.
Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	<p>From the 1999 Youth Risk Behavior Surveillance System:</p> <ul style="list-style-type: none"> ➤ <i>Have you ever had sexual intercourse?</i> ➤ <i>During the past three months, with how many people have you had sexual intercourse?</i> <ul style="list-style-type: none"> <i>I have never had sexual intercourse</i> <i>I have had sexual intercourse, but not in the past 3 months</i> <i>1 person</i> <i>2 people</i> <i>3 people</i> <i>4 people</i> <i>5 people</i> <i>6 or more people</i> ➤ <i>The last time you had sexual intercourse, did you or your partner use a condom?</i> <ul style="list-style-type: none"> <i>I have never had sexual intercourse</i> <i>yes</i> <i>no</i>
Expected Periodicity	Biennial.
Comments	<p>This measure is a modification of Healthy People 2000 objectives 5.5 and 5.6, which tracked the proportion of sexually active in-school adolescents in grades 9 through 12 that abstained from sexual intercourse in the past 3 months and used contraception at most recent intercourse, respectively. This measure tracks the proportion of adolescents in grades 9 through 12 who have never had sexual intercourse; <u>or</u> who have had sexual intercourse, but not in the past 3 months; <u>or</u> have had sexual intercourse in the past 3 months but used a condom at last sexual intercourse.</p> <p>This objective is one of the measures used to track the Responsible Sexual Behavior Leading Health Indicator. See Appendix H for a complete listing.</p>

See Part C for a description of YRBSS and Appendix A for focus area contact information.



25-12. (Developmental) Increase the number of positive messages related to responsible sexual behavior during weekday and nightly prime-time television programming.

Comments	An operational definition could not be specified at the time of publication. The proposed national data source is CDC, NCHSTP. Responsible sexual behavior includes abstinence, delaying sexual intercourse, or using condoms. See Appendix A for focus area contact information.
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Community Protection Infrastructure

25-13. Increase the proportion of Tribal, State, and local sexually transmitted disease programs that routinely offer hepatitis B vaccines to all STD clients.

National Data Source	Survey of STD Programs, National Coalition of STD Directors (NCSD).
State Data Source	Survey of STD Programs, National Coalition of STD Directors (NCSD).
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	5 (1998).
Numerator	Number of State and local STD clinics that reported all clients are eligible to receive the hepatitis B vaccine.
Denominator	Number of STD programs (free-standing facilities with the capacity to diagnose and treat STDs).

Questions Used to Obtain the National Data

From the 1998 Survey of STD Programs:

- *Who is eligible for the hepatitis B vaccine in STD clinics?*

Expected Periodicity

Periodic.

Comments

This measure tracks the proportion of programs that offer hepatitis B vaccines to clients in accordance with CDC guidelines.³

The numerator is the number of facilities that report “hepatitis vaccines are offered to all clients” to the question listed above.

The Survey of STD Programs is a national convenience sample of free-standing facilities with the capacity to diagnose and treat STDs.

Data for Tribes are developmental. The proposed national data source is the Indian Health Service (IHS).

See Appendix A for focus area contact information.



25-14. (Developmental) Increase the proportion of youth detention facilities and adult city or county jails that screen for common bacterial sexually transmitted diseases within 24 hours of admission and treat STDs (when necessary) before persons are released.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the Annual Survey of Correctional Facilities, CDC, NCHSTP and National Institute of Justice; U.S. Department of Justice, U.S. Bureau of Justice Statistics.

See Appendix A for focus area contact information.

25-15. (Developmental) Increase the proportion of all local health departments that have contracts with managed care providers for the treatment of nonplan partners of patients with bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia).

Comments An operational definition could not be specified at the time of publication.

 The proposed national data source is the Survey of STD Programs, National Coalition of STD Directors (NCSD).

 This objective is modified from Healthy People 2000 objective 19.15, which tracked partner notification of exposure to sexually transmitted by patients with bacterial STDs using the STDSS.

 See Appendix A for focus area contact information.



Personal Health Services

25-16. (Developmental) Increase the proportion of sexually active females aged 25 years and under who are screened annually for genital chlamydia infections.

Comments An operational definition could not be specified at the time of publication.

 The proposed national data sources are the Office on Population Affairs (OPA) data reported in Family Planning Annual Report and the STD Surveillance System (STDSS), CDC, NCHSTP.

 Primary health care centers include: family planning clinics, community health centers, university health services, Department of Defense health clinics for active duty military, and managed care plans.

 See Appendix A for focus area contact information.

25-17. (Developmental) Increase the proportion of pregnant females screened for sexually transmitted diseases (including HIV infection and bacterial vaginosis) during prenatal health care visits, according to recognized standards.

Comments

An operational definition could not be specified at the time of publication.

The proposed measure is the percent of pregnant females screened for STDs in community health centers, and the proposed data sources are the Department of Defense health clinics for active duty military and managed care plans data from the STD Surveillance System (STDSS), CDC, NCHSTP.

Recognized standards are the most recent edition of the *Guide to Clinical Preventive Services*.⁴

See Appendix A for focus area contact information.



25-18. Increase the proportion of primary care providers who treat patients with sexually transmitted diseases and who manage cases according to recognized standards.

Comments

An operational definition was not specified at the time of publication.

The national data source for the 1998 baseline is the National Disease and Therapeutic Index (NDTI), IMS America. The proposed tracking source is the National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS.

This objective is modified from Healthy People 2000 objective 19.13, which tracked correct management of sexually transmitted disease cases by primary care providers using the NDTI.

See Part C for a description of NAMCS and Appendix A for focus area contact information.



25-19. (Developmental) Increase the proportion of sexually transmitted disease clinic patients who are being treated for bacterial STDs (chlamydia, gonorrhea, and syphilis) and who are offered provider referral services for their sex partners.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is STD Surveillance System (STDSS), CDC, NCHSTP.

Provider referral (previously called contact tracing) is the process whereby health department personnel directly and confidentially notify the sexual partners of infected individuals of their exposure to a sexually transmitted disease for the purposes of education, counseling, and referral to health care services.

This objective is modified from Healthy People 2000 objective 19.15, which tracked partner notification of exposure to sexually transmitted diseases by patients with bacterial STDs using STDSS.

See Appendix A for focus area contact information.



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1. Centers for Disease Control and Prevention (CDC). Case definitions for infectious conditions under public health surveillance. *Morbidity and Mortality Weekly Report* 46 (RR-10): 1997.
2. CDC, Division of STD Prevention. *Sexually Transmitted Disease Surveillance, 1997*. Atlanta, GA: U.S. Department of Health and Human Services (HHS), Public Health Service, CDC, 1998.
3. CDC. Hepatitis B virus: A comprehensive strategy for eliminating transmission in the United States through universal childhood vaccination: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *Morbidity and Mortality Weekly Report* 40(RR-13):1-20, 1991.
4. U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services*. 2nd ed. Washington, DC: HHS, 1995.

26

Substance Abuse

Adverse Consequences of Substance Use and Abuse

- 26-1 Motor vehicle crash deaths and injuries
 - 26-1a Alcohol-related deaths
 - 26-1b Alcohol-related injuries
 - 26-1c Drug-related deaths
 - 26-1d Drug-related injuries
- 26-2 Cirrhosis deaths
- 26-3 Drug-induced deaths
- 26-4 Drug-related hospital emergency department visits
- 26-5 Alcohol-related hospital emergency department visits
- 26-6 Adolescents riding with a driver who has been drinking
- 26-7 Alcohol- and drug-related violence
- 26-8 Lost productivity

Substance Use and Abuse

- 26-9 Substance-free youth
 - 26-9a Average age at first use, alcohol
 - 26-9b Average age at first use, marijuana
 - 26-9c High school seniors never using substances - Alcohol
 - 26-9d High school seniors never using substances - Illicit drugs
- 26-10 Adolescent and adult use of illicit substances
 - 26-10a Youth using no alcohol or illicit drugs in past 30 days
 - 26-10b Youth using marijuana in past 30 days
 - 26-10c Adults using any illicit drug in past 30 days
- 26-11 Binge drinking
 - 26-11a High school seniors
 - 26-11b College students
 - 26-11c Adults aged 18 years and older
 - 26-11d Adolescents aged 12 to 17 years
- 26-12 Average annual alcohol consumption

- 26-13 Low-risk drinking among adults
- 26-13a Females
- 26-13b Males
- 26-14 Steroid use among adolescents
- 26-14a 8th graders
- 26-14b 10th graders
- 26-14c 12th graders
- 26-15 Inhalant use among adolescents

Risk of Substance Use and Abuse

- 26-16 Peer disapproval of substance abuse
 - One or two alcoholic drinks
 - 26-16a 8th graders
 - 26-16b 10th graders
 - 26-16c 12th graders
 - Trying marijuana or hashish
 - 26-16d 8th graders
 - 26-16e 10th graders
 - 26-16f 12th graders
- 26-17 Perception of risk associated with substance abuse
 - 26-17a Alcohol
 - 26-17b Marijuana
 - 26-17c Cocaine

Treatment for Substance Abuse

- 26-18 Treatment gap for illicit drugs
- 26-19 Treatment in correctional institutions
- 26-20 Treatment for injection drug use
- 26-21 Treatment gap for problem alcohol use

State and Local Efforts

- 26-22 Hospital emergency department referrals
- 26-23 Community partnerships and coalitions
- 26-24 Administrative license revocation laws
- 26-25 Blood alcohol concentration (BAC) levels for motor vehicle drivers

Adverse Consequences of Substance Use and Abuse

26-1. Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.

26-1a. Alcohol-related deaths.

National Data Source	Fatality Analysis Reporting System (FARS), DOT, NHTSA.
State Data Sources	Police Accident Reports (PARs) (account for 90 percent of the data) and State Traffic Record Systems.
Healthy People 2000 Objective	4.1 (Substance Abuse: Alcohol and Other Drugs) (also 9.23).
Measure	Rate per 100,000 population.
Baseline	5.9 (1998).
Numerator	Number of alcohol-related motor vehicle crash deaths.
Denominator	Number of persons.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>NHTSA defines a fatal crash as alcohol related if either a driver or a nonmotorist has a measurable or estimated blood alcohol concentration (BAC) of 0.01 g/dL or above.</p> <p>BAC is measured as a percentage by weight of alcohol in the blood (expressed as grams per deciliter). A positive BAC level (0.01 g/dL and higher) indicates that alcohol was consumed by the person tested. A BAC of 0.10 g/dL or more indicates that the person was intoxicated.</p> <p>Only deaths that occur within 30 days of the motor vehicle crash are included (less than 2 percent of the total number of deaths occur after 30 days).</p>

FARS data are obtained solely from a State's existing documents, including police crash reports, death certificates (coded to ICD-9 E810-E819), vehicle registration files, and hospital medical reports.

A description of the FARS data set has been published by NHTSA.¹

See Appendix A for focus area contact information.



26-1b. Alcohol-related injuries.

National Data Source	General Estimates System (GES), DOT, NHTSA.
State Data Sources	Police Accident Reports (PARs) (account for 90 percent of the data) and State Traffic Record Systems.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 100,000 population.
Baseline	113 (1998).
Numerator	Number of alcohol-related motor vehicle injuries.
Denominator	Number of persons.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>NHTSA defines a nonfatal crash as alcohol related if police indicated on the police accident report that there was evidence of alcohol present. The code does not necessarily mean that a driver or occupant was tested for alcohol.</p> <p>The national estimates produced from GES data may differ from the true values because they are based on a probability sample of crashes and not a census of all crashes. The size of these differences may also vary depending on which sample of crashes is selected.</p>

A description of the GES data set has been published by NHTSA.¹

See Appendix A for focus area contact information.



26-1c. (Developmental) Drug-related deaths.

Comments An operational definition could not be specified at the time of publication.

See Appendix A for focus area contact information.



26-1d. (Developmental) Drug-related injuries.

Comments An operational definition could not be specified at the time of publication.

See Appendix A for focus area contact information.



26-2. Reduce cirrhosis deaths.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	4.2 (Substance Abuse: Alcohol and Other Drugs), age adjusted to the 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	9.5 (1998).
Numerator	Number of deaths due to cirrhosis (ICD-9 code 571).
Denominator	Number of persons.
Population Targeted	U.S. resident population.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion of age adjustment, see Part A, section 5.</p> <p>This objective differs from Healthy People 2000 objective 4.2, which age adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.</p> <p>See Part C for a description of NVSS and Appendix A for focus area contact information.</p>



26-3. Reduce drug-induced deaths.

National Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
State Data Source	National Vital Statistics System (NVSS), CDC, NCHS.
Healthy People 2000 Objective	4.3 (Substance Abuse: Alcohol and Other Drugs), age adjusted to the 2000 standard population.
Measure	Rate per 100,000 population (age adjusted—see Comments).
Baseline	6.3 (1998).
Numerator	Number of deaths due to drug-induced causes (ICD-9 codes 292, 304, 305.2-305.9, E850-E858, E950.0-E950.5, E962.0, E980.0-E980.5).
Denominator	Number of persons.
Population Targeted	U.S. resident population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.

Comments

Drug-induced causes of death include not only deaths from dependent and nondependent use of drugs (legal and illegal use), but also poisoning from medically prescribed and other drugs. It excludes accidents, homicides, and other causes indirectly related to drug use. An indepth description of the “drug-induced causes” classification was published by NCHS.²

Data are age adjusted to the 2000 standard population. Age-adjusted rates are weighted sums of age-specific rates. For a discussion of age adjustment, see Part A, section 5.

This objective differs from Healthy People 2000 objective 4.3, which age adjusted the death rates using the 1940 standard population. See Appendix C for comparison data.

See Part C for a description of NVSS and Appendix A for focus area contact information.



26-4. Reduce drug-related hospital emergency department visits.

National Data Source	Drug Abuse Warning Network (DAWN), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.4 (Substance Abuse: Alcohol and Other Drugs).
Measure	Number.
Baseline	542,544 (1998).
Numerator	Number of emergency department (ED) visits by patients aged 6 to 97 years that were due to the use of illegal drugs or the nonmedical use of legal drugs.
Denominator	Not applicable.
Population Targeted	U.S. resident population.

Questions Used To Obtain the National Data

From the 1998 Drug Abuse Warning Network-Emergency Department Report Form:

- (Item 5): Age - Must be 06-97 yrs.
- (Item 9): Reason for taking substance(s) - Mark 'X' one response.
 - Dependence
 - Suicide attempt or gesture
 - Psychic effects: "Recreational use" (e.g., to get high, kicks)
 - Other psychic effects
 - Unknown
 - Other (Specify)
- (Item 12): Alcohol involved - Mark 'X' one response.
- (Item 13): List each drug/substance separately in one of the spaces below - Do NOT list alcohol [Four spaces are provided].
- (Item 16): Source of substance - For each non-alcohol substance listed above, mark 'X' one response.
 - Patient's own legal Rx
 - Street buy
 - Other unauthorized procurement (e.g., stolen, gift, etc.)
 - Other (includes over-the-counter (OTC))
 - Unknown

Expected Periodicity

Annual.

Comments

Nonmedical use is the use of a drug or substance for the purpose of dependence, suicide attempt or gesture, or psychic effect. All prescription drugs, over-the-counter drugs, and substances (heroin/morphine, marijuana/hashish, peyote, glue, aerosols, etc.) are considered.

Alcohol is included only if it is combined with other substances.

The Drug Abuse Warning Network (DAWN) monitors drug-related hospital ED episodes in 21 metropolitan areas and a national sample of hospitals outside the metropolitan areas. Episodes are abstracted from medical records by hospital staff or hired clerks. DAWN gathers data from a nationally representative sample of 508 non-Federal, short-stay hospitals with 24-hour EDs. Data are weighted to produce national estimates.

DAWN reflects drug use among those who use the emergency departments but is not an indication of the overall prevalence of drug use. Changes in the trends can occur due to changes in ED access, drug use prevalence, severity of problems associated with the drugs used, or access to other settings of care.

Information on DAWN can be obtained from the SAMHSA Web site: <http://www.samhsa.gov>.

This objective is adapted from Healthy People 2000 objective 4.4 which measured ED visits as a rate per 100,000 population.

See Appendix A for focus area contact information.



26-5. (Developmental) Reduce alcohol-related hospital emergency department visits.

Comments

An operational definition could not be specified at the time of publication.

The proposed data source is the National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.

See Part C for a description of NHAMCS and Appendix A for focus area contact information.



26-6. Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.

Baseline	33 (1999).
Numerator	Number of students in grades 9 through 12 who reported riding, at least once during the 30 days preceding the survey, with a driver who had been drinking alcohol.
Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	From the 1999 Youth Risk Behavior Surveillance System: ➤ <i>During the past 30 days, how many times did you ride in a car or other vehicle driven by someone who had been drinking alcohol?</i> zero times 1 time 2 or 3 times 4 or 5 times 6 or more times
Expected Periodicity	Biennial.
Comments	See Part C for a description of YRBSS and Appendix A for focus area contact information.



26-7. (Developmental) Reduce intentional injuries resulting from alcohol- and illicit drug-related violence.

Comments	An operational definition could not be specified at the time of publication. A proposed source of data for this objective is the National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics. See Appendix A for focus area contact information.
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26-8. (Developmental) Reduce the cost of lost productivity in the workplace due to alcohol and drug use.

Comments	An operational definition could not be specified at the time of publication.
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Proposed sources of data for this objective are the periodic estimates of economic costs of alcohol and drug use, NIH, NIAAA and NIDA.

See Appendix A for focus area contact information.



Substance Use and Abuse

26-9. Increase the age and proportion of adolescents who remain alcohol and drug free.

Average age at first use

26-9a. Alcohol.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	4.5 (Substance Abuse: Alcohol and Other Drugs (also 3.19).
Measure	Mean.
Baseline	13.1 (1998).
Numerator	Sum of reported ages at first use of alcohol by adolescents aged 12 to 17 years.
Denominator	Number of adolescents aged 12 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Household Survey on Drug Abuse: ➤ <i>How old were you the first time you had a drink of any alcoholic beverage? Do not include sips from another person's drink. If you can't remember exactly how old you were, make your best guess of (the) one specific age.</i>
Expected Periodicity	Annual.

Comments

Baseline data are collected from respondents who complete anonymous, confidential answer sheets. Since 1999, the respondents have provided answers on laptop computers rather than using paper and pencil answer sheets. This change in methodology may result in some differences in response rates, which will be analyzed and adjusted.

See Part C for a description of NHSDA and Appendix A for focus area contact information.

**26-9b. Marijuana.**

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	4.5 (Substance Abuse: Alcohol and Other Drugs) (also 3.19).
Measure	Mean.
Baseline	13.7 (1998).
Numerator	Sum of reported ages at first use of marijuana by adolescents aged 12 to 17 years.
Denominator	Number of adolescents aged 12 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Household Survey on Drug Abuse:</p> <p>➤ <i>How old were you the first time you used marijuana or hashish? If you're not sure how old you were, make your best guess.</i></p>
Expected Periodicity	Annual.
Comments	See Comments provided with objective 26-9a for more information



High school seniors never using substances

26-9c. Alcoholic beverages.

National Data Source Monitoring the Future Study (MTF), NIH, NIDA (see Comments).

State Data Source Not identified.

Healthy People 2000 Objective Not applicable.

Measure Percent.

Baseline 19 (1998).

Numerator Number of 12th grade students who report never using alcohol.

Denominator Number of 12th grade students.

Population Targeted Students in public and private schools in the coterminous United States.

Questions Used To Obtain the National Data From the 1998 Monitoring the Future Study:

- *On how many occasions (if any) have you had alcohol to drink - more than just a few sips... ... in your lifetime? ... during the last 12 months? ... during the last 30 days?*

[Mark one circle for each line. Response categories include:]

*0 occasions
1-2 occasions
3-5 occasions
6-9 occasions
10-19 occasions
20-39 occasions
40 or more*

Expected Periodicity Annual.

Comments Students are considered to have never used alcohol if they respond they drank alcohol on 0 occasions in their lifetime. Data are based on students in attendance on the day of the survey administration.

Once data from the expanded NHSDA are available in the year 2001, the data source for this objective will be reexamined.

See Part C for a description of MTF and Appendix A for focus area contact information.



26-9d. Illicit drugs.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	46 (1998).
Numerator	Number of 12th grade students who report never using illicit drugs.
Denominator	Number of 12th grade students
Population Targeted	Students in public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	<p>From the 1998 Monitoring the Future Study:</p> <ul style="list-style-type: none">➤ <i>On how many occasions (if any) have you used marijuana (weed, pot) or hashish?</i>➤ <i>On how many occasions (if any) have you used LSD ("acid")?</i>➤ <i>On how many occasions (if any) have you used psychedelics other than LSD (like mescaline, peyote, psilocybin, PCP)?</i>➤ <i>On how many occasions (if any) have you taken amphetamines on your own—that is, without a doctor telling you to take them?</i>➤ <i>On how many occasions (if any) have you used cocaine (sometimes called "coke," "crack," "rock")?</i>➤ <i>On how many occasions (if any) have you used heroin?</i>➤ <i>On how many occasions (if any) have you taken narcotics other than heroin on your own—that is, without a doctor telling you to take them?</i>➤ <i>On how many occasions (if any) have you taken tranquilizers on your own—that is, without a doctor telling you to take them?</i>

Expected Periodicity	Annual.
Comments	<p>Use of any illicit drug includes <u>any</u> use of marijuana, LSD, other hallucinogens, crack, other forms of cocaine, or heroin or any use of other opiates, stimulants, barbiturates, or tranquilizers not under a doctor's orders.</p> <p>See Comments provided with objective 26-9c for more information.</p>



26-10. Reduce past-month use of illicit substances.

26-10a. Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Leading Health Indicator	Substance Abuse.
Healthy People 2000 Objective	4.5 (Substance Abuse: Alcohol and Other Drugs) (also 3.19).
Measure	Percent.
Baseline	79 (1998).
Numerator	Number of adolescents aged 12 to 17 years who reported not using any alcohol or illicit drugs during the past 30 days.
Denominator	Number of adolescents aged 12 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Household Survey on Drug Abuse:

- *Think about the last time you drank any type of alcoholic beverage. How long has it been since you last drank an alcoholic beverage?*

If you last drank an alcoholic beverage within the past 30 days, mark the first box.

If it has been more than 30 days ago but within the past 12 months that you last drank an alcoholic beverage, mark the second box.

If it was more than 12 months ago but within the past 3 years, mark the third box.

If it has been more than 3 years since you last drank an alcoholic beverage, mark the fourth box.

If you have never drunk an alcoholic beverage in your life, mark the last box.

[The following question is asked separately for each illicit drug: marijuana or hashish, cocaine, "crack," heroin, hallucinogens, and inhalants:]

- *How long has it been since you last used [marijuana or hashish]?*

If your answer is within the past 30 days, mark the first box.

If your answer is more than 30 days ago but within the past 12 months, mark the second box.

If your answer is more than 12 months ago but within the past 3 years, mark the third box.

If your answer is more than 3 years ago, mark the next-to-last box.

If you have never used [marijuana/hashish] in your life, mark the last box.

[The following questions are asked separately for non-medical use of the following: analgesics (prescription pain killers), tranquilizers, stimulants, and sedatives:]

- *As you read the following list of [analgesics (prescription pain killers)/tranquilizers/stimulants/sedatives], please mark one box beside each [analgesic (prescription pain killer)/tranquilizer/stimulant/sedative] to indicate whether you have ever used that [analgesic (prescription pain killer)/tranquilizer/stimulant/sedative] when it was not prescribed for you, or that you took only for the experience or feeling it caused. Again, we are interested in all kinds of [analgesics (prescription pain killers)/tranquilizers/stimulants/sedatives], in pill or non-pill form.*

[This question is followed by a list of common drugs specific to each of the following categories: analgesics (prescription pain killers), tranquilizers, stimulants, and sedatives.]

- *Have you ever used a [analgesic (prescription pain killer)/tranquilizer/stimulant/sedative] whose name you don't know that was not prescribed for you, or that you took only for the experience or feeling it caused? If "YES," mark the first box, if "NO," mark the second box.*
- *Have you ever used an other [analgesic (prescription pain killer)/tranquilizer/stimulant/sedative] besides the ones listed above, that was not prescribed for you, or that you took only for the experience or feeling it caused? PLEASE PRINT NAME(S) OF OTHER [ANALGESICS (PRESCRIPTION PAIN KILLERS)/TRANQUILIZERS/STIMULANTS/SEDATIVES] BELOW. If "YES," mark the first box, if "NO," mark the second box.*

[If the respondent reported use of any [analgesic (prescription pain killer)/tranquilizer/stimulant/sedative] they are asked:]

- *How long has it been since you last used [an analgesic (prescription pain killer)/tranquilizer/stimulant/sedative] that was not prescribed for you, or that you took only for the experience or feeling it caused?*

If your answer is within the past 30 days, mark the first box.

If your answer is more than 30 days ago but within the past 12 months, mark the second box.

If your answer is more than 12 months ago but within the past 3 years, mark the third box.

If your answer is more than 3 years ago, mark the next-to-last box.

Expected Periodicity

Annual.

Comments

Alcohol or illicit drug use by adolescents aged 12 to 17 years is defined as using at least one of the following substances in the past month: alcohol, marijuana or hashish, cocaine (including "crack"), inhalants, hallucinogens (including PCP and LSD), heroin, or any nonmedical use of analgesics, tranquilizers, stimulants, or sedatives.

The answers for each of the substances are examined for each respondent. Persons are considered to have not used alcohol or illicit drugs if they report no use in the past 30 days of any one of the substances.

This objective is one of the measures used to track the Substance Abuse Leading Health Indicator. See Appendix H for a complete listing.

See Part C for a description of NHSDA and
Appendix A for focus area contact information.



**26-10b. Reduce the proportion of adolescents reporting use of
marijuana during the past 30 days.**

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	4.6 (Substance Abuse: Alcohol and Other Drugs) (also 3.20).
Measure	Percent.
Baseline	8.3 (1998).
Numerator	Number of adolescents aged 12 to 17 years who report using marijuana during past 30 days.
Denominator	Number of adolescents aged 12 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 26-10a.
Expected Periodicity	Annual.
Comments	Respondents are considered to have used marijuana or hashish if they report use of either substance in the past 30 days. See Part C for a description of NHSDA and Appendix A for focus area contact information.



**26-10c. Reduce the proportion of adults using any illicit drug during
the past 30 days.**

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.

Leading Health Indicator	Substance Abuse.
Healthy People 2000 Objective	4.5 (Substance Abuse: Alcohol and Other Drugs) (also 3.19).
Measure	Percent.
Baseline	5.8 (1998).
Numerator	Number of adults aged 18 years and older who report use of any illicit drugs during the past 30 days.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 26-10a.
Comments	<p>Illicit drug use is defined as using <u>at least one</u> of the following substances in the past month: marijuana or hashish, cocaine (including “crack”), inhalants, hallucinogens (including PCP and LSD), heroin, or any nonmedical use of analgesics, tranquilizers, stimulants, or sedatives.</p> <p>Respondents are considered to have used illicit drugs if they report use in the past 30 days of any of the listed substances.</p> <p>This objective is one of the measures used to track the Substance Abuse Leading Health Indicator. See Appendix H for a complete listing.</p> <p>See Part C for a description of NHSDA and Appendix A for focus area contact information.</p>



26-11. Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.

26-11a. High school seniors.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.

Healthy People 2000 Objective	4.7 (Substance Abuse: Alcohol and Other Drugs).
Measure	Percent.
Baseline	32 (1998).
Numerator	Number of 12th grade students who report drinking five or more alcoholic beverages in a row during the 2 weeks prior to the survey.
Denominator	Number of 12th grade students.
Population Targeted	Students in public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	<p>From the 1998 Monitoring the Future Study:</p> <p>➤ <i>Think back over the LAST TWO WEEKS. How many times have you had five or more drinks in a row? (A "drink" is a glass of wine, a bottle of beer, a wine cooler, a shot glass of liquor, or a mixed drink).</i></p> <p><i>None</i> <i>Once</i> <i>Twice</i> <i>Three to five times</i> <i>Six to nine times</i> <i>Ten or more times</i></p>
Expected Periodicity	Annual.
Comments	<p>Data are based on students in attendance on the day of the survey administration.</p> <p>This objective uses the same measurement protocol as the comparable Healthy People 2000 objective (4.7). The only difference is that "five or more drinks" was called "heavy drinking" and is now considered "binge drinking."</p> <p>See Part C for a description of MTF and Appendix A for focus area contact information.</p>



26-11b. College students.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.

Healthy People 2000 Objective	4.7 (Substance Abuse: Alcohol and Other Drugs).
Measure	Percent.
Baseline	39 (1998).
Numerator	Number of college students who report drinking five or more alcoholic beverages in a row during the 2 weeks prior to the survey.
Denominator	Number of college students.
Population Targeted	Students in public and private colleges and universities in the coterminous United States.
Questions Used To Obtain the National Data	<p>From the 1998 Monitoring the Future Study:</p> <p>➤ <i>Think back over the LAST TWO WEEKS. How many times have you had five or more drinks in a row? (A "drink" is a glass of wine, a bottle of beer, a wine cooler, a shot glass of liquor, or a mixed drink).</i></p> <p><i>None</i> <i>Once</i> <i>Twice</i> <i>Three to five times</i> <i>Six to nine times</i> <i>Ten or more times</i></p>
Expected Periodicity	Annual.
Comments	See Comments provided with objective 26-11a for more information.



26-11c. Adults aged 18 years and older.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Leading Health Indicator	Substance Abuse.
Healthy People 2000 Objective	Adapted from 4.7 (Substance Abuse: Alcohol and Other Drugs).
Measure	Percent.
Baseline	16.6 (1998).

Numerator	Number of adults aged 18 years and older who report having five or more drinks at the same time or within a couple of hours of each other during the 30 days prior to the survey.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Household Survey on Drug Abuse:</p> <p>➤ <i>During the past 30 days, on how many days did you have 5 or more drinks on the same occasion? By "occasion," we mean at the same time or within a couple of hours of each other.</i></p> <p><i>On the solid line, write the number of days in the past 30 days when you drank 5 or more drinks of an alcoholic beverage on the same occasion.</i></p> <p><i>If you never had 5 or more drinks on the same occasion on any day when you drank during the past 30 days, mark the first box.</i></p> <p><i>If you have drunk alcoholic beverages, but not during the past 30 days, mark the second box.</i></p> <p><i>If you have never drunk an alcoholic beverage in your life, mark the last box.</i></p>
Expected Periodicity	Annual.
Comments	<p>Binge drinking is defined as drinking five or more alcoholic beverages at the same time or within a couple hours of each other during the past 30 days.</p> <p>For the 1998 baseline, there are two ways of handling missing values to calculate binge drinking rates: (1) eliminating persons who drink but have missing values on this item from the calculation of binge drinkers and, (2) counting persons who drink but have missing values on this item as a person who does NOT binge. In the future, missing values for drinkers will be imputed.</p> <p>This objective differs from Healthy People 2000 objective 4.7 in four ways: (1) the tracking of adults aged 18 years and older is new to Healthy People 2010, (2) "five or more drinks" was called "heavy drinking" and is now considered "binge drinking," (3) this measure is tracked by the NHSDA, rather than the MFT survey, and (4) the time frame is 30 days rather than 2 weeks.</p>

This objective is one of the measures used to track the Substance Abuse Leading Health Indicator. See Appendix H for a complete listing.

See Part C for a description of NHSDA and Appendix A for focus area contact information.



26-11d. Adolescents aged 12 to 17 years.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.7 (Substance Abuse: Alcohol and Other Drugs).
Measure	Percent.
Baseline	7.7 (1998).
Numerator	Number of adolescents aged 12 to 17 years who report having five or more drinks at the same time or within a couple of hours of each other during the 30 days prior to the survey.
Denominator	Number of adolescents aged 12 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 26-11c.
Expected Periodicity	Annual.
Comments	<p>This objective differs from Healthy People 2000 objective 4.7 in four ways: (1) the tracking of adolescents aged 12 to 17 years is new to Healthy People 2010, (2) "five or more drinks" was called "heavy drinking" and is now considered "binge drinking," (3) this measure is tracked by the NHSDA, rather than the MTF survey, and (4) the time frame is 30 days rather than 2 weeks.</p> <p>See Comments provided with objective 26-11c for more information.</p>



26-12. Reduce average annual alcohol consumption.

National Data Source	Alcohol Epidemiologic Data System (AEDS), NIH, NIAAA.
State Data Source	Not identified.
Healthy People 2000 Objective	4.8 (Substance Abuse: Alcohol and Other Drugs).
Measure	Rate per person.
Baseline	2.18 (1997).
Numerator	Number of gallons of ethanol sold in the United States.
Denominator	Number of persons aged 14 years and older.
Population Targeted	U.S. noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The number of gallons of ethanol (pure alcohol) sold in the U.S. is used as a proxy for annual consumption of alcoholic beverages.</p> <p>AEDS received beverage sales and/or tax receipts reports for 1997 from 19 States. For the remaining States and the District of Columbia, shipment data from major beverage industry sources were used for the numerator to calculate per capita consumption.</p> <p>AEDS uses an estimate of average ethanol content in the alcoholic beverages to convert the gallons of sold or shipped beer, wine, and spirits into gallons of ethanol before calculating per capita estimates.</p> <p>A description of AEDS was published by NIAAA.³</p> <p>See Appendix A for focus area contact information.</p>



26-13. Reduce the proportion of adults who exceed guidelines for low-risk drinking.

26-13a. Females.

National Data Source	National Longitudinal Alcohol Epidemiologic Survey (NLAES), NIH, NIAAA.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	72 (1992).
Numerator	Number of females aged 21 years and older who reported drinking more than seven drinks per week or more than three drinks on any day in the past 12 months.
Denominator	Number of female current drinkers aged 21 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1992 National Longitudinal Alcohol Epidemiologic Survey:</p> <ul style="list-style-type: none">➤ <i>Over the past 12 months, did you have at least 12 drinks of any kind of alcohol?</i>➤ <i>During the last 12 months, did you drink any beer?</i><ul style="list-style-type: none">[If yes:]○ <i>During the last 12 months, about how often did you drink any beer?</i>○ <i>Now I'd like to know the size of the can, bottle, or glass off beer that you USUALLY drank. What was the size of the TYPICAL can, bottle, or glass of beer that you drank during the last 12 months?</i>○ <i>On the days when you drank beer in the last 12 months, about how many (cans/bottles/glasses) of beer did you USUALLY drink in a single day?</i>○ <i>During the last 12 months, what was the LARGEST number of (cans/bottles/glasses) of beer that you drank in a single day?</i>

- *About how often did you drink (largest number) (cans/bottles/glasses) of beer in a single day?*
- *During the last 12 months, did you drink any wine, wine coolers, champagne or sparkling wine?*
 - [If yes:]
 - *During the last 12 months, about how often did you drink any wine, wine coolers, champagne or sparkling wine?*
 - *Now I'd like to know the size of the glass or bottle of wine or wine cooler that you USUALLY drank. What was the size of the TYPICAL bottle or glass of wine that you drank during the last 12 months?*
 - *On the days when you drank wine in the last 12 months, about how many (glasses/bottles/carafes) of wine did you USUALLY drink in a single day?*
 - *During the last 12 months, what was the LARGEST number of (glasses/bottles/carafes) of wine that you drank in a single day?*
 - *About how often did you drink (largest number) (glasses/bottles/carafes) of wine in a single day?*
- *During the last 12 months, did you drink any liquor, including mixed drinks and liqueurs?*
 - [If yes:]
 - *During the last 12 months, about how often did you drink any liquor?*
 - *Now I'd like to know how much liquor was in a TYPICAL drink you had. How many ounces or shots of liquor did you USUALLY have in a drink? Please do not include the amount of any soda, water, ice, cola or juice that may have been added to your drink.*
 - *On the days when you drank liquor in the last 12 months, about how many drinks did you USUALLY have in a single day?*
 - *During the last 12 months, what was the LARGEST number of drinks of liquor that you drank in a single day?*
 - *About how often did you drink (largest number) drinks of liquor in a single day?*
- *During the last 12 months, about how often did you have five or more drinks of any type of alcohol in a single day?*

Expected Periodicity

Periodic.

Comments

Current drinkers were defined as those who answered “yes” to the question asking whether they drank 12 or more drinks in the last year.

The number of drinks consumed per week was calculated as follows:

- (1) The responses to all frequency questions (“About how often...”) were converted to days per year, using the midpoints of the categorical response options (for example, 1 to 2 days a week was converted to $1.5 \times 52 = 78$ days per year).
- (2) For each type of beverage (beer, wine, and liquor), the annual volume of intake was calculated as [(total frequency minus frequency of drinking largest amount) x (usual quantity of drinks) x (size of drink in ounces) x (ethanol content by volume)] + [(frequency of drinking largest amount) x (largest quantity of drinks) x (size of drink in ounces) x (ethanol content by volume)], where the ethanol content by volume was estimated at .045 for beer, .121 for wine and .409 for liquor.
- (3) The three beverage-specific volumes were summed to yield the overall annual volume of intake in ounces, which was divided by 52 to yield the average weekly ethanol intake in ounces.
- (4) The average weekly ethanol intake was converted to a number of standard drinks by dividing by 0.54 ounces, the amount of ethanol assumed to be contained in a standard drink. A value of greater than 14 was excessive for men, and a value of greater than 7 was excessive for women.

In assessing the number of standard drinks consumed on any day, the usual and largest quantities of beer, wine, and liquor were each converted to standard drinks as follows: [(quantity of drinks) x (drink size in ounces) x (ethanol content by volume)]/0.54. A value of greater than 4 for any of the usual or largest quantities was considered excessive for men, and a value of greater than 3 for any of the usual or largest quantities was considered excessive for women. In addition, any non-zero response to the question on frequency of drinking five or more drinks was considered excessive for men and women.

Missing values for the question that asked about drinking at least 12 drinks in the past year were imputed on the basis of whether the subsequent questions were filled in or left blank. If no more than three of the questions concerning beer, wine, and liquor were missing, they were imputed using modal responses to those items. Frequency of drinking five or more drinks was not imputed. After imputation, cases that still had missing data for any of the questions used in the calculations were removed from both the numerator and denominator of the percent.

A description of the 1992 NLAES was published in a peer-reviewed journal.⁴

See Appendix A for focus area contact information.



26-13b. Males.

National Data Source	National Longitudinal Alcohol Epidemiologic Survey (NLAES), NIH, NIAAA.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	74 (1992).

Numerator	Number of males aged 21 years and older who reported drinking more than 14 drinks per week and/or more than 4 drinks on any day in the past 12 months.
Denominator	Number of male current drinkers aged 21 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 26-13a.
Expected Periodicity	Periodic.
Comments	See Comments provided with objective 26-13a for more information.



26-14. Reduce steroid use among adolescents.

26-14a. 8th graders.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.11 (Substance Abuse: Alcohol and Other Drugs).
Measure	Percent.
Baseline	1.2 (1998).
Numerator	Number of 8th grade students who reported using steroids in the past year.
Denominator	Number of 8th grade students.
Population Targeted	Students in public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	From the 1998 Monitoring the Future Study:

- *Steroids, or anabolic steroids, are sometimes prescribed by doctors to promote healing from certain types of injuries. Some athletes, and others, have used them to try to increase muscle development. On how many occasions (if any) have you taken steroids on your own--that is, without a doctor telling you to take them?*

... in your lifetime?"

... during the last 12 months?

... during the last 30 days?

[Mark one circle for each line. Response categories include:]

0 Occasions

1-2 Occasions

3-5 Occasions

6-9 Occasions

10-19 Occasions

20-39 Occasions

40 or More

Expected Periodicity

Annual.

Comments

Students are considered to have used steroids if they respond that they used steroids on one or more occasions during the last 12 months or during the last 30 days.

Data are based on students in attendance on the day of the survey administration.

This objective differs from Healthy People 2000 objective 4.11, which was limited to male high school seniors.

See Part C for a description of MTF and Appendix A for focus area contact information.



26-14b. 10th graders.

National Data Source

Monitoring the Future Study (MTF), NIH, NIDA.

State Data Source

Not identified.

Healthy People 2000 Objective

Adapted from 4.11 (Substance Abuse: Alcohol and Other Drugs).

Measure

Percent.

Baseline

1.2 (1998).

Numerator	Number of 10th grade students who reported using steroids in the past year.
Denominator	Number of 10th grade students.
Population Targeted	Students in public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 26-14a.
Expected Periodicity	Annual.
Comments	<p>This objective differs from Healthy People 2000 objective 4.11, which was limited to males and did not track 10th grade students.</p> <p>See Comments provided with objective 26-14a for more information.</p>



26-14c. 12th graders.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.11 (Substance Abuse: Alcohol and Other Drugs).
Measure	Percent.
Baseline	1.7 (1998).
Numerator	Number of 12th grade students who reported using steroids in the past year.
Denominator	Number of 12th grade students.
Population Targeted	Students in public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 26-14a.
Expected Periodicity	Annual.
Comments	This objective differs from Healthy People 2000 objective 4.11, which was limited to tracking males.



26-15. Reduce the proportion of adolescents who use inhalants.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	2.9 (1998).
Numerator	Number of adolescents aged 12 to 17 years who reported using inhalants during the past year.
Denominator	Number of adolescents aged 12 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Household Survey on Drug Abuse:</p> <ul style="list-style-type: none"> ➤ <i>Please mark one box beside each type of inhalant to indicate whether you have <u>ever</u> used that kind of inhalant, even once, for kicks or to get high. On each line, mark the box on the left for "YES" if you have <u>ever</u> used that kind of inhalant, even once. Mark the box on the right for "NO" if you have never used any inhalant of that kind.</i> ➤ <i>Have you ever, even once, inhaled amyl nitrite, "popper," locker room odorizers, or "rush" for kicks or to get high?</i> ➤ <i>Have you ever, even once, inhaled correction fluid, degreaser, or cleaning fluid for kicks or to get high?...</i> <i>Gasoline or lighter fluid?...</i> <i>Glue, shoe polish, or toluene?...</i> <i>Halothane, ether, or other anesthetics?...</i> <i>Lacquer thinner or other paint solvents?...</i> <i>Lighter gases, such as butane or propane?...</i> <i>Nitrous oxide or "whippets"?...</i> <i>Spray paints?</i> ➤ <i>Have you ever, even once, inhaled some other aerosol spray for kicks or to get high?</i>

- *Have you ever used any inhalant whose name you don't know, for kicks or to get high?*
- *Have you ever used any other inhalants for kicks or to get high besides the ones I've named from this list?*

[If yes:]

- *Now think about the past 12 months. On how many days in the past 12 months did you use an inhalant for kicks or to get high?*

Mark the first box for more than 300 days (which is every day or almost every day).

Mark the second for at least 201 but not more than 300 days (5 to 6 days a week).

Mark the next for at least 101 but not more than 200 days (3 to 4 days a week).

Mark the next for at least 51 but not more than 100 days (1 to 2 days a week).

Mark the next for at least 25 but not more than 50 days (3 to 4 days a month).

Mark the next for at least 12 but not more than 24 days (1 to 2 days a month).

Mark the next for at least 6 but not more than 11 days (less than one day a month).

Mark the next for at least 3 but not more than 5 days in the past 12 months.

And mark the third from the last for at least 1 but not more than 2 days in the past 12 months.

If you have used inhalants for kicks or to get high, but not during the past 12 months, mark the next-to-last box.

If you have never used any inhalant for kicks or to get high in your life, mark the last box.

Expected Periodicity

Annual.

Comments

Use of inhalants within the past year was defined by an affirmative response to ever using any kind of inhalant “for kicks or to get high” combined with a response of “at least one, but not more than 2 days in the past 12 months” or more frequently.

Specific inhalants that have been identified as used “for kicks or to get high” are listed to help the respondent remember and to let the respondent know the kinds of substances of interest. In addition, probes are added for other substances. These two approaches tend to increase the probability that inhalant users will report their use

See Part C for a description of NHSDA and Appendix A for focus area contact information.



Risk of Substance Use and Abuse

26-16. Increase the proportion of adolescents who disapprove of substance abuse.

One or two alcoholic drinks nearly every day

26-16a. 8th graders.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.9 (Substance Abuse: Alcohol and Other Drugs) (also 3.21).
Measure	Percent.
Baseline	77 (1998).
Numerator	Number of 8th grade students who report their disapproval of people who take one or two drinks nearly every day.
Denominator	Number of 8th grade students.
Population Targeted	Public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	<p>From the 1998 Monitoring the Future Study:</p> <p>➤ <i>Individuals differ in whether or not they disapprove of people doing certain things. Do YOU disapprove of people doing each of the following?</i></p> <p>[Response categories "a" through "p" include:]</p> <p><i>j. Taking one or two drinks nearly every day....</i></p> <p><i>Don't disapprove</i> <i>Disapprove</i> <i>Strongly disapprove</i> <i>Can't say, Drug Unfamiliar</i></p>
Expected Periodicity	Annual.
Comments	<p>Disapproval is defined as those who report that they "disapprove" or "strongly disapprove."</p> <p>Data are based on students in attendance on the day of the survey administration.</p>

This objective differs from Healthy People 2000 objective 4.9, which measures perception of disapproval by others and is limited to tracking 12th grade students.

See Part C for a description of MTF and Appendix A for focus area contact information.



26-16b. 10th graders.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.9 (Substance Abuse: Alcohol and Other Drugs) (also 3.21).
Measure	Percent.
Baseline	75 (1998).
Numerator	Number of 10th grade students who report their disapproval of people who take one or two drinks nearly every day.
Denominator	Number of 10th grade students.
Population Targeted	Public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 26-16a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 26-16a for more information.



26-16c. 12th graders.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.9 (Substance Abuse: Alcohol and Other Drugs) (also 3.21).

Measure	Percent.
Baseline	69 (1998).
Numerator	Number of 12th grade students who report their disapproval of people who take one or two drinks nearly every day.
Denominator	Number of 12th grade students.
Population Targeted	Public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 26-16a.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 26-16a for more information.



Trying marijuana or hashish once or twice

26-16d. 8th graders.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.9 (Substance Abuse: Alcohol and Other Drugs) (also 3.21).
Measure	Percent.
Baseline	69 (1998).
Numerator	Number of 8th grade students who report their disapproval of people who try marijuana once or twice.
Denominator	Number of 8th grade students.
Population Targeted	Public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	From the 1998 Monitoring the Future Study:

- *Individuals differ in whether or not they disapprove of people doing certain things. Do YOU disapprove of people doing each of the following?*

[Response categories “a” through “p” include:]

c. Trying marijuana once or twice....

Don't disapprove

Disapprove

Strongly disapprove

Can't say, Drug Unfamiliar

Expected Periodicity

Annual.

Comments

Disapproval is defined as those who report they “disapprove” or “strongly disapprove.”

Data are based on students in attendance on the day of the survey administration.

This objective differs from Healthy People 2000 objective 4.9, which measures perception of disapproval by others.

See Part C for a description of MTF and Appendix A for focus area contact information.



26-16e. 10th graders.

National Data Source

Monitoring the Future Study (MTF), NIH, NIDA.

State Data Source

Not identified.

Healthy People 2000 Objective

Adapted from 4.9 (Substance Abuse: Alcohol and Other Drugs) (also 3.21).

Measure

Percent.

Baseline

56 (1998).

Numerator

Number of 10th grade students who report their disapproval of people who try marijuana once or twice.

Denominator

Number of 10th grade students.

Population Targeted

Public and private schools in the coterminous United States.

Questions Used To Obtain the National Data

See Questions Used To Obtain the National Data provided with objective 26-16d.

Expected Periodicity	Annual.
Comments	See Comments provided with objective 26-16d for more information.



26-16f. 12th graders.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.9 (Substance Abuse: Alcohol and Other Drugs) (also 3.21).
Measure	Percent.
Baseline	52 (1998).
Numerator	Number of 12th grade students who report their disapproval of people who try marijuana once or twice.
Denominator	Number of 12th grade students.
Population Targeted	Public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 26-16d.
Expected Periodicity	Annual.
Comments	See Comments provided with objective 26-16d for more information.



26-17. Increase the proportion of adolescents who perceive great risk associated with substance abuse.

26-17a. Consuming five or more drinks at a single occasion once or twice a week.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.

Healthy People 2000 Objective	4.10 (Substance Abuse: Alcohol and Other Drugs) (also 3.22).
Measure	Percent.
Baseline	47 (1998).
Numerator	Number of adolescents aged 12 to 17 years who report that they perceive great risk from consuming five or more drinks on a single occasion once or twice a week.
Denominator	Number of adolescents aged 12 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Household Survey on Drug Abuse:</p> <p>➤ <i>How much do people risk harming themselves physically and in other ways when they have five or more drinks once or twice a week? Is there:</i></p> <p><i>No risk?</i> <i>Slight risk?</i> <i>Moderate risk?</i> <i>Great risk?</i></p>
Expected Periodicity	Annual.
Comments	<p>While the question used to obtain baseline data takes into account all kinds of harm, some respondents may focus on physical harm only. Consequently the measure is a very conservative estimate of the perceived harm.</p> <p>This objective uses the same measurement protocol as the comparable Healthy People 2000 objective (4.10). The only difference is that “five or more drinks” was called “heavy use of alcohol” in the Healthy People 2000 objective.</p> <p>See Part C for a description of NHSDA and Appendix A for focus area contact information.</p>



26-17b. Smoking marijuana once per month.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.

Healthy People 2000 Objective	4.10 (Substance Abuse: Alcohol and Other Drugs) (also 3.22).
Measure	Percent.
Baseline	31 (1998).
Numerator	Number of adolescents aged 12 to 17 years who report they perceive great risk from smoking marijuana once a month.
Denominator	Number of adolescents aged 12 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Household Survey on Drug Abuse:</p> <p>➤ <i>How much do people risk harming themselves physically and in other ways when they smoke marijuana once a month?</i></p> <p><i>Mark the first box if you think there is no risk.</i> <i>Mark the second box if you think there is slight risk.</i> <i>Mark the third box if you think there is moderate risk.</i> <i>Mark the fourth box if you think there is great risk.</i></p>
Expected Periodicity	Annual.
Comments	<p>While the question used to obtain baseline data takes into account all kinds of harm, some respondents may focus on physical harm only. Consequently the measure is a very conservative estimate of the perceived harm.</p> <p>This objective uses the same measurement protocol as the comparable Healthy People 2000 objective (4.10). The only difference is that “smoking marijuana once a month” was called “regular use of marijuana” in the Healthy People 2000 objective.</p> <p>See Part C for a description of NHSDA and Appendix A for focus area contact information.</p>



26-17c. Using cocaine once per month.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.

Healthy People 2000 Objective	Adapted from 4.10 (Substance Abuse: Alcohol and Other Drugs) (also 3.22).
Measure	Percent.
Baseline	54 (1998).
Numerator	Number of adolescents aged 12 to 17 years who report they perceive great risk from using cocaine once a month.
Denominator	Number of adolescents aged 12 to 17 years.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Household Survey on Drug Abuse:</p> <p>➤ <i>How much do people risk harming themselves physically and in other ways when they use cocaine once a month? Is there:</i></p> <p><i>No risk?</i> <i>Slight risk?</i> <i>Moderate risk?</i> <i>Great risk?</i></p>
Expected Periodicity	Annual.
Comments	<p>While the question used to obtain baseline data takes into account all kinds of harm, some respondents may focus on physical harm only. Consequently the measure is a very conservative estimate of the perceived harm.</p> <p>This objective differs from Healthy People 2000 objective 4.10, which measured perceived harm from trying cocaine once or twice.</p> <p>See Part C for a description of NHSDA and Appendix A for focus area contact information.</p>



Treatment for Substance Abuse

26-18. (Developmental) Reduce the treatment gap for illicit drugs in the general population.

Comments	An operational definition could not be specified at the time of publication.
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A proposed data source for this objective is the National Household Survey on Drug Abuse (NHSDA), SAMHSA.

The treatment gap is the difference between the number of persons who need treatment for the use of illicit drugs and the number of persons who are receiving treatment in a given year. There are ongoing discussions among Federal agencies and organizations in the drug abuse field, including SAMHSA, the Office of National Drug Control Policy, and the National Association of State Alcohol and Drug Abuse Directors, to develop an accurate measure.

See Part C for a description of MTF and Appendix A for focus area contact information.



26-19. (Developmental) Increase the proportion of inmates receiving substance abuse treatment in correctional institutions.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source for this objective is the Uniform Facilities Data Set Survey of Correctional Facilities, SAMHSA, OAS.

See Appendix A for focus area contact information.



26-20. Increase the number of admissions to substance abuse treatment for injection drug use.

National Data Source

Treatment Episodes Data System (TEDS), SAMHSA, OAS.

State Data Source

State administrative data.

Healthy People 2000 Objective

Not applicable.

Measure

Number.

Baseline

167,960 (1997).

Numerator	Number of admissions for injection drug use in substance abuse treatment programs.
Denominator	Not applicable.
Population Targeted	Public and private nonprofit substance abuse treatment program population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>TEDS data are not based on a statistical data collection system. TEDS data are continuously submitted to SAMHSA by States from their administrative data systems. The States collect data from substance abuse treatment providers, primarily from publicly-funded treatment programs. Each State uses its own form for collecting information on substance abuse admissions. When data are submitted to SAMHSA, data are matched to the core variables contained in TEDS. There is a considerable time lag between the date of admission and when SAMHSA receives data from each State.</p> <p>SAMHSA publishes data in tabular form in an annual report.</p> <p>See Appendix A for focus area contact information.</p>



26-21. (Developmental) Reduce the treatment gap for alcohol problems.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>A proposed data source for this objective is the National Household Survey on Drug Abuse (NHSDA), SAMHSA.</p>
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The measure will focus on problem drinking derived from an 11-item scale. The exact size of the gap between services available and services needed has not yet been determined. Depending on the jurisdiction, there is wide variability in treatment capacity and how that capacity is distributed among settings and modalities.

See Part C for a description of NHSDA and Appendix A for focus area contact information.



State and Local Efforts

26-22. (Developmental) Increase the proportion of patients who are referred for followup care for alcohol problems, drug problems, or suicide attempts after diagnosis or treatment for one of these conditions in a hospital emergency department.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source for this objective is the National Hospital Ambulatory Medical Care Survey, (NHAMCS), CDC, NCHS.

See Part C for a description of NHAMCS and Appendix A for focus area contact information.



26-23. (Developmental) Increase the number of communities using partnerships or coalition models to conduct comprehensive substance abuse prevention efforts.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source for this objective is the Community Partnerships Data, SAMHSA.

See Appendix A for focus area contact information.



26-24. Extend administrative license revocation laws, or programs of equal effectiveness, for persons who drive under the influence of intoxicants.

National Data Source	DOT, NHTSA.
State Data Source	Not identified.
Healthy People 2000 Objective	4.15 (Substance Abuse: Alcohol and Other Drugs).
Measure	Number.
Baseline	41 States and the District of Columbia (1998).
Numerator	Number of States, including the District of Columbia, that have passed administrative license revocation (ALR) legislation or equivalent programs.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	A complete operational definition was not specified at the time of publication. See Appendix A for focus area contact information.



26-25. Extend legal requirements for maximum blood alcohol concentration levels of 0.08 percent for motor vehicle drivers aged 21 years and older.

National Data Source	DOT, NHTSA.
State Data Source	Police Accident Reports (PARs).
Healthy People 2000 Objective	4.18 (Substance Abuse: Alcohol and Other Drugs).
Measure	Number.
Baseline	16 (1998).

Numerator	Number of States, including the District of Columbia, with maximum blood alcohol concentration (BAC) levels of 0.08 percent for motor vehicle drivers aged 21 years and older.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>A complete operational definition was not specified at the time of publication.</p> <p>BAC is measured as a percentage by weight of alcohol in the blood (grams per deciliter). A positive BAC level (0.01 g/dL and higher) indicates that alcohol was consumed by the person tested. A BAC of 0.10 g/dL or more indicates that the person was intoxicated.</p> <p>One of the major differences among States is in the degree of testing for driver and non-occupant BACs.</p> <p>See Appendix A for focus area contact information.</p>



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27

Tobacco Use

Tobacco Use in Population Groups

- 27-1 Adult tobacco use
 - 27-1a Cigarette smoking
 - 27-1b Spit tobacco
 - 27-1c Cigars
 - 27-1d Other products
- 27-2 Adolescent tobacco use
 - 27-2a Tobacco products
 - 27-2b Cigarettes
 - 27-2c Spit tobacco
 - 27-2d Cigars
- 27-3 Initiation of tobacco use
- 27-4 Age at first tobacco use
 - 27-4a Adolescents aged 12 to 17 years
 - 27-4b Young adults aged 18 to 25 years

Cessation and Treatment

- 27-5 Smoking cessation by adults
- 27-6 Smoking cessation during pregnancy
- 27-7 Smoking cessation by adolescents
- 27-8 Insurance coverage of cessation treatment
 - 27-8a Managed care organizations
 - 27-8b Medicaid programs
 - 27-8c All insurance

Exposure to Secondhand Smoke

- 27-9 Exposure to tobacco smoke at home among children
- 27-10 Exposure to environmental tobacco smoke
- 27-11 Smoke-free and tobacco-free schools
- 27-12 Worksite smoking policies

- 27-13 Smoke-free indoor air laws
 - 27-13a Private workplaces
 - 27-13b Public workplaces
 - 27-13c Restaurants
 - 27-13d Public transportation
 - 27-13e Day care centers
 - 27-13f Retail stores
 - 27-13g Tribes
 - 27-13h Territories

Social and Environmental Changes

- 27-14 Enforcement of illegal tobacco sales to minors laws
 - 27-14a States and District of Columbia
 - 27-14b Territories
- 27-15 Retail license suspension for sales to minors
- 27-16 Tobacco advertising and promotion targeting adolescents and young adults
- 27-17 Adolescent disapproval of smoking
 - 27-17a 8th graders
 - 27-17b 10th graders
 - 27-17c 12th graders
- 27-18 Tobacco control programs
- 27-19 Preemptive tobacco control laws
- 27-20 Tobacco product regulation
- 27-21 Tobacco tax
 - 27-21a Cigarettes
 - 27-21b Spit tobacco

Tobacco Use in Population Groups

27-1. Reduce tobacco use by adults.

27-1a. Cigarette smoking.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	3.4 (Tobacco) (also 15.12 and 16.6), age adjusted to the 2000 standard population.
Leading Health Indicator	Tobacco Use.
Measure	Percent (age adjusted—see Comments).
Baseline	24 (1998).
Numerator	Number of adults aged 18 years and older who have smoked at least 100 cigarettes in lifetime and who now report smoking cigarettes everyday or some days.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>➤ <i>Have you smoked at least 100 cigarettes in your entire life?</i></p> <p>[If yes:]</p> <p>○ <i>Do you now smoke cigarettes everyday, some days, or not at all?</i></p>
Expected Periodicity	Annual.
Comments	Persons are considered as using cigarettes if they report that they smoked at least 100 cigarettes in their lifetime and now report smoking cigarettes everyday or some days.

Starting in 1992, NHIS has defined current smokers as persons who have smoked at least 100 cigarettes and now smoke either everyday or some days. The 1992 inclusion of intermittent smoking increased the prevalence of smoking by approximately one percent compared with estimates derived from the previous smoking definition.

For State data, 1996 and later questions from the BRFSS are the same as those presented for 1998 NHIS.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

This objective is one of the measures used to track the Tobacco Use Leading Health Indicator. See Appendix H for a complete listing.

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



27-1b. Spit tobacco.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent (age adjusted—see Comments).
Baseline	2.6 (1998).
Numerator	Number of adults 18 years and older who report using snuff or chewing tobacco at least 20 times in their lifetime and now use it everyday or some days.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey:

- *Have you used snuff such as Skoal, Skoal Bandits, or Copenhagen at least 20 times in your entire life?*

[If yes:]

- *Do you now use snuff everyday, some days, or not at all?*

- *Have you ever used chewing tobacco such as Redman, Levi Garrett, or Beechnut at least 20 times in your entire life?*

[If yes:]

- *Do you now use chewing tobacco everyday, some days, or not at all?*

Expected Periodicity

Periodic.

Comments

Persons are classified as using either snuff or chewing tobacco if they answer “yes” to either use of snuff or use of chewing tobacco, and they report using the snuff or chewing tobacco “everyday” or “some days.”

For State data, the 1998 BRFSS (Optional Module) contains questions similar, but not identical, to NHIS questions.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



27-1c. Cigars.

National Data Source

National Health Interview Survey (NHIS), CDC, NCHS.

State Data Source

Not identified—see Comments.

Healthy People 2000 Objective

Not applicable.

Measure

Percent (age adjusted—see Comments).

Baseline

2.5 (1998).

Numerator	Number of adults 18 years and older who report having smoked at least 50 cigars in lifetime and now smoke cigars everyday or some days.
Denominator	Number of adults aged 18 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <p>➤ <i>Have you ever smoked cigars?</i></p> <p>[If yes:]</p> <ul style="list-style-type: none"> ○ <i>Have you smoked at least 50 cigars in your entire life?</i> ○ <i>Do you now smoke cigars everyday, some days, or not at all?</i>

Expected Periodicity Periodic.

Comments Persons are classified as smoking cigars if they answer “yes” to smoking 50 cigars in their lifetime, and report smoking cigars “everyday” or “some days.”

For State data, questions on cigar smoking for the 2001 BRFSS (Optional Module) are proposed. They are not identical to the NHIS questions.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



27-1d. (Developmental) Other products.

Comments An operational definition could not be specified at the time of publication.

Other products are expected to include pipes, bidis, and possibly other herbal cigarettes. The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS, and the proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

The 1998 NHIS asked the following questions to obtain pipe smoking data: Have you ever smoked pipes? (If yes,) Have you smoked at least 50 pipes in your entire life? Do you now smoke pipes everyday, some days, or not at all?

See Part C for a description of NHIS and Appendix A for focus area contact information.



27-2. Reduce tobacco use by adolescents.

27-2a. Tobacco products (past month).

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 3.9 (Tobacco) (also 13.17) and 4.6 (Substance Abuse: Alcohol and Other Drugs) (also 3.20).
Measure	Percent.
Baseline	40 (1999).
Numerator	Number of students in grades 9 through 12 who report using cigarettes, spit tobacco, or cigars on 1 or more of the 30 days preceding the survey.
Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	From the 1999 Youth Risk Behavior Surveillance System: ➤ <i>During the past 30 days, on how many days did you smoke cigarettes?</i>

- *During the past 30 days, on how many days did you use chewing tobacco or snuff, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?*
- *During the past 30 days, on how many days did you smoke any cigars, cigarillos, or little cigars?*

Expected Periodicity

Biennial.

Comments

Students are classified as using tobacco if they report using at least one of the tobacco products on 1 or more of the 30 days preceding the survey.

This objective differs from Healthy People 2000 objectives 3.9 and 4.6 in two ways. For the Healthy People 2000 objectives, the national data source was the National Household Survey on Drug Abuse (NHSDA), SAMHSA, and the targeted age group was 12 to 17 years.

See Part C for a description of YRBSS and Appendix A for focus area contact information.



27-2b. Cigarettes (past month).

National Data Source

Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

State Data Source

Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Healthy People 2000 Objective

Adapted from 4.6 (Substance Abuse: Alcohol and Other Drugs) (also 3.20).

Leading Health Indicator

Tobacco Use.

Measure

Percent.

Baseline

35 (1999).

Numerator

Number of students in grades 9 through 12 who reported having smoked cigarettes on 1 or more of the 30 days preceding the survey.

Denominator

Number of students in grades 9 through 12.

Population Targeted

Students in grades 9 through 12.

Questions Used To Obtain the National Data	<p>From the 1999 Youth Risk Behavior Survey:</p> <p>➤ <i>During the past 30 days, on how many days did you smoke cigarettes?</i></p>
Expected Periodicity	Biennial.
Comments	<p>This objective differs from Healthy People 2000 objective 4.6 in two ways. For the Healthy People 2000 objective, the national data source was the National Household Survey on Drug Abuse (NHSDA), SAMHSA, and the targeted age group was 12 to 17 years.</p> <p>This objective is one of the measures used to track the Tobacco Use Leading Health Indicator. See Appendix H for a complete listing.</p> <p>See Part C for a description of YRBSS and Appendix A for focus area contact information.</p>



27-2c. Spit tobacco (past month).

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Adapted from 3.9 (Tobacco) (also 13.17).
Measure	Percent.
Baseline	8 (1999).
Numerator	Number of students in grades 9 through 12 who reported having used smokeless (chewing tobacco or snuff) tobacco on 1 or more of the 30 days preceding the survey.
Denominator	Number of students in grades 9 through 12.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	From the 1999 Youth Risk Behavior Surveillance System:

- *During the past 30 days, on how many days did you use chewing tobacco or snuff, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?*

Expected Periodicity

Biennial.

Comments

This objective differs from Healthy People 2000 objective 3.9 in two ways. For the Healthy People 2000 objective, the national data source was the National Household Survey on Drug Abuse (NHSDA), SAMHSA, and the targeted age group was 12 to 17 years.

See Part C for a description of YRBSS and Appendix A for focus area contact information.



27-2d. Cigars (past month).

National Data Source

Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

State Data Source

Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Healthy People 2000 Objective

Not applicable.

Measure

Percent.

Baseline

18 (1999).

Numerator

Number of students in grades 9 through 12 who reported having smoked cigars on 1 or more of the 30 days preceding the survey.

Denominator

Number of students in grades 9 through 12.

Population Targeted

Students in grades 9 through 12.

Questions Used To Obtain the National Data

From the 1999 Youth Risk Behavior Surveillance System:

- *During the past 30 days, on how many days did you smoke any cigars, cigarillos, or little cigars?*

Expected Periodicity

Biennial.

Comments

See Part C for a description of YRBSS and Appendix A for focus area contact information.

27-3. (Developmental) Reduce the initiation of tobacco use among children and adolescents.

Comments	<p>An operational definition could not be specified at the time of publication. A proposed data source is the National Household Survey on Drug Abuse (NHSDA), SAMHSA.</p> <p>This objective is modified from Healthy People 2000 objective 3.5 (Tobacco).</p> <p>See Appendix A for focus area contact information.</p>
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27-4. Increase the average age of first use of tobacco products by adolescents and young adults.

27-4a. Adolescents aged 12 to 17 years.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	4.5 (Substance Abuse: Alcohol and Other Drugs) (also 3.19).
Measure	Mean.
Baseline	12 (1997).
Numerator	Sum of the ages of first cigarette use of adolescents aged 12 to 17 years who ever smoked, including those who ever smoked one or two puffs in their lifetime.
Denominator	Number of adolescents aged 12 to 17 years who ever smoked, including those who ever smoked one or two puffs in their lifetime.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1997 National Household Survey on Drug Abuse:</p> <p>➤ <i>How old were you the first time you smoked a cigarette, even one or two puffs?</i></p> <p><i>The first time I smoked a cigarette I was _____ years old.</i></p> <p><i>I have never smoked a cigarette in my life.</i></p>

Expected Periodicity	Annual.
Comments	See Part C for a description of NHSDA and Appendix A for focus area contact information.



27-4b. Young adults aged 18 to 25 years.

National Data Source	National Household Survey on Drug Abuse (NHSDA), SAMHSA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.5 (Substance Abuse: Alcohol and Other Drugs) (also 3.19).
Measure	Mean.
Baseline	15 (1997).
Numerator	Sum of the ages of first cigarette use of young adults aged 18 to 25 years who ever smoked, including those who ever smoked one or two puffs in their lifetime.
Denominator	Number of young adults aged 18 to 25 years who ever smoked cigarettes, including those who ever smoked one or two puffs in their lifetime.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	See Questions Used To Obtain the National Data provided with objective 27-4a.
Expected Periodicity	Annual.
Comments	<p>This objective differs from Healthy People 2000 objective 4.5, which did not target the age group of 18 to 25 years.</p> <p>See Part C for a description of NHSDA and Appendix A for focus area contact information.</p>



Cessation and Treatment

27-5. Increase smoking cessation attempts by adult smokers.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 3.6 (Tobacco).
Measure	Percent (age adjusted—see Comments).
Baseline	41 (1998).
Numerator	Number of current, everyday cigarette smokers aged 18 years and older who quit smoking for 1 day or longer during the 12 months prior to the interview.
Denominator	Number of adults in the survey population aged 18 years and older who are current, everyday cigarette smokers.
Population Targeted	U.S. civilian noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1998 National Health Interview Survey:</p> <ul style="list-style-type: none">➤ <i>Have you smoked at least 100 cigarettes in your entire life?</i><ul style="list-style-type: none">[If yes:]<ul style="list-style-type: none">○ <i>Do you now smoke cigarettes everyday, some days, or not at all?</i><ul style="list-style-type: none">[If yes:]<ul style="list-style-type: none">▪ <i>During the past 12 months, have you stopped smoking for 1 day or longer BECAUSE YOU WERE TRYING TO QUIT SMOKING?</i>
Expected Periodicity	Annual.
Comments	Adults are classified as current smokers if they report currently smoking cigarettes “everyday” or “some days.”

This objective is measured differently than Healthy People 2000 objective 3.6. For objective 3.6, the question asked, "During the past 12 months, have you quit smoking for 1 day or longer?" Beginning in 1997, the question on quitting smoking was modified by adding "because you were trying to quit smoking," and may affect trends.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

See Part C for a description of NHIS and Appendix A for focus area contact information.



27-6. Increase smoking cessation during pregnancy.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 3.7 (Tobacco).
Measure	Percent.
Baseline	14 (1998).
Numerator	Number of females aged 18 to 49 years who reported having a live birth in the past 5 years and smoking at any time during their pregnancy with their last child and who quit smoking in their first trimester and stayed off cigarettes for the rest of their pregnancy.
Denominator	Number of females aged 18 to 49 years who reported having a live birth in the past 5 years and smoking at any time during their pregnancy with their last child.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1998 National Health Interview Survey: <ul style="list-style-type: none"> ➤ <i>(Has/have) (you/Person) given birth to a liveborn infant in the past 5 years?</i>

[If yes:]

- *Were you smoking cigarettes when you became pregnant with your last child?*

[If yes:]

- *Did you smoke cigarettes at any time during your pregnancy with your last child?*

[If yes:]

- *Did you quit smoking for 7 days or longer during your pregnancy with your last child?*

[If yes:]

- *In what month of your pregnancy did you first quit for 7 days or longer?*
- *Did you start smoking again during that pregnancy or did you stay off cigarettes for the rest of the pregnancy?*

Expected Periodicity

Periodic.

Comments

Females classified as smoking during pregnancy and quitting are those who answered “Yes” to smoking at any time during their pregnancy with their last child, “Yes” to quitting smoking for 7 days or longer, reported that the month they quit was the first through the third, and answered “No” to starting smoking again during the pregnancy.

This objective is measured differently than Healthy People 2000 objective 3.7. For objective 3.7, the numerator was the number of females who quit smoking for 7 days or longer during their most recent pregnancy in the past 5 years. Quitting in the first trimester was not measured. Healthy People 2010 objective 27-6 specifies quitting in the first trimester (months 1 through 3), and adds a specific question about smoking cigarettes at any time during pregnancy with the last child.

See Part C for a description of NHIS and Appendix A for focus area contact information.



27-7. Increase tobacco use cessation attempts among adolescent smokers.

National Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
State Data Source	Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.
Healthy People 2000 Objective	Not applicable.
Measure	Percent.
Baseline	76 (1999).
Numerator	Number of students in grades 9 through 12 who ever smoked at least one cigarette everyday for 30 days and ever tried to quit smoking cigarettes.
Denominator	Number of students in grades 9 through 12 who ever smoked at least one cigarette everyday for 30 days.
Population Targeted	Students in grades 9 through 12.
Questions Used To Obtain the National Data	<p>From the 1999 Youth Risk Behavior Surveillance System:</p> <ul style="list-style-type: none">➤ <i>Have you ever tried cigarette smoking, even one or two puffs?</i><ul style="list-style-type: none">[If yes:]<ul style="list-style-type: none">○ <i>During the past 30 days, on how many days did you smoke cigarettes?</i><ul style="list-style-type: none">0 days1 or 2 days3 to 5 days6 to 9 days10 to 19 days20 to 29 daysAll 30 days➤ <i>Have you ever tried to quit smoking cigarettes?</i>
Expected Periodicity	Biennial.
Comments	See Part C for a description of YRBSS and Appendix A for focus area contact information.



27-8. Increase insurance coverage of evidence-based treatment for nicotine dependency.

27-8a. Managed care organizations.

National Data Source	Addressing Tobacco in Managed Care: 1997–98 Health Plan Survey (ATMC), Robert Wood Johnson Foundation.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 3.24 (Tobacco).
Measure	Percent.
Baseline	75 (1997–98).
Numerator	Number of managed care organizations with health plans that partially or fully covered one or more smoking cessation interventions.
Denominator	Number of managed care organizations.
Population Targeted	Managed care organizations.
Questions Used To Obtain the National Data	<p>From the Addressing Tobacco in Managed Care: 1997–98 Health Plan Survey:</p> <p>➤ <i>Which of the following cessation interventions are available in your plan and which are included in your plan's formulary?</i></p> <p><i>Nicotine Replacement therapy:</i></p> <p><i>Over-the-counter</i></p> <p><i>Prescription</i></p> <p><i>Only w/ enrollment in cessation program</i></p> <p><i>Bupropion (for example, Zyban)</i></p> <p><i>Telephone counseling</i></p> <p><i>Face-to-face counseling</i></p> <p><i>Classes or group meeting</i></p> <p><i>Self-help materials</i></p> <p>[Response categories: mark all that apply:]</p> <p><i>Unavailable;</i></p> <p><i>Full coverage;</i></p> <p><i>Partial coverage;</i></p> <p><i>In formulary</i></p>
Expected Periodicity	Periodic.

Comments	<p>The ATMC survey will not be repeated. However, the American Association of Health Plans will be surveying managed care organizations annually, with selected tobacco-related questions every 2 or 3 years.</p> <p>This objective is measured by a different data source than Healthy People 2000 objective 3.24, which had no updates to the 1985 baseline during the decade.</p> <p>See Appendix A for focus area contact information.</p>
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27-8b. Medicaid programs in States and the District of Columbia.

National Data Source	Health Policy Tracking Service, National Conference of State Legislators.
State Data Source	Health Policy Tracking Service, National Conference of State Legislators.
Healthy People 2000 Objective	Adapted from 3.24 (Tobacco).
Measure	Number.
Baseline	24 (1998).
Numerator	Number of Medicaid programs in States and the District of Columbia that cover smoking cessation services, including counseling and nicotine replacement therapies.
Denominator	Number of Medicaid programs in States and the District of Columbia.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Periodic.
Comments	See Appendix A for focus area contact information.



27-8c. (Developmental) All insurance.

Comments	An operational definition could not be specified at the time of publication. This objective is modified from Healthy People objective 3.24 (Tobacco). See Appendix A for focus area contact information.
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Exposure to Secondhand Smoke

27-9. Reduce the proportion of children who are regularly exposed to tobacco smoke at home.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	3.8 (Tobacco).
Measure	Percent.
Baseline	27 (1994).
Numerator	Number of children aged 6 years and under living in households where a household resident smoked inside the home at least 4 days a week.
Denominator	Number of households with children aged 6 years and under.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1994 National Health Interview Survey: ➤ <i>Does ANYONE who lives here smoke cigarettes, cigars, or pipes ANYWHERE INSIDE this home?</i> ➤ <i>On the average, about how many days per week do people who live here smoke ANYWHERE INSIDE this home?</i>
Expected Periodicity	Periodic.
Comments	Only households with children aged 6 years and under are used in the calculation.

The first update for this objective will not be comparable to the baseline. In the 1998 NHIS questionnaire, the wording of the second question in the two-question series was changed to: On the average, about how many DAYS PER WEEK is there smoking ANYWHERE INSIDE this home?

See Part C for a description of NHIS and Appendix A for focus area contact information.



27-10. Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.

National Data Source	National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Leading Health Indicator	Environmental Quality.
Measure	Percent (age adjusted—see Comments).
Baseline	65 (1988–94).
Numerator	Number of nonsmokers aged 4 years and older who had a serum cotinine level above 0.10 ng/mL.
Denominator	Number of nonsmokers aged 4 years and older.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	<p>From the 1988–94 National Health and Nutrition Examination Survey:</p> <p>[For ages 8 years and older:]</p> <ul style="list-style-type: none"> ➤ <i>How many cigarettes have you smoked in the past 5 days?</i> ➤ <i>How many pipes and how many cigars have you smoked in the past 5 days?</i> ➤ <i>How many containers of chewing tobacco or snuff have you used in the past 5 days?</i>

- *How many pieces of nicotine gum have you chewed in the past 5 days? (Nicotine gum is a sugar-free flavored chewing gum prescribed by a doctor to help people stop smoking or chewing tobacco.)*

Expected Periodicity

Annual, beginning with 1999 data.

Comments

Children aged 4 to 7 years are classified as nonsmokers. Children aged 8 years and older are classified as nonsmokers if the responses to all four types of nicotine exposure were "0" or "None." Only responses to the questions asked of persons who participated in the examination component of the survey were used, so that serum levels of cotinine could be available for analysis.

Data are age adjusted to the 2000 standard population. Age-adjusted percents are weighted sums of age-specific percents. For a discussion on age adjustment, see Part A, section 5.

This objective is one of the measures used to track the Environmental Quality Leading Health Indicator. See Appendix H for a complete listing.

See Part C for a description of NHANES and Appendix A for focus area contact information.



27-11. Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events.

National Data Source

School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

State Data Source

School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

Healthy People 2000 Objective

Adapted from 3.10 (Tobacco).

Measure

Percent.

Baseline

37 (1994).

Numerator	Number of junior high, middle, and senior high schools that reported that no smoking or no smokeless tobacco use was allowed by students, staff, or visitors on school facilities, property, vehicles, and school events.
Denominator	Number of junior high, middle, and senior high schools.
Population Targeted	Public and private junior high, middle, and senior high schools.
Questions Used To Obtain the National Data	<p>From the 1994 School Health Policies and Programs Study:</p> <p>Handcard #1:</p> <p style="padding-left: 40px;"> <i>School building</i> <i>School grounds</i> <i>School-sponsored events off-campus</i> <i>School vehicles</i> </p> <p>[Show Handcard #1]</p> <p>➤ <i>I'm going to ask you a series of questions about <u>student smoking policies</u>. By smoking, I mean all forms of smoking tobacco, including cigarettes, pipes, and cigars. Looking at <u>Handcard #1</u>, are students permitted to smoke in any of these places during regular school hours?</i></p> <p style="padding-left: 40px;">[If yes:]</p> <ul style="list-style-type: none"> ○ <i>Where are students permitted to smoke during regular school hours?</i> ○ <i>Are students permitted to smoke in any of these places during <u>non-school hours</u>?</i> <p>[Show Handcard #1]</p> <p>➤ <i>I'm going to ask you the same series of questions about <u>student smokeless tobacco use policies</u>. By smokeless tobacco, I mean snuff or chewing tobacco. Looking at <u>Handcard #1</u>, are students permitted to use smokeless tobacco in any of these places during <u>regular school hours</u>?</i></p> <p style="padding-left: 40px;">[If yes:]</p> <ul style="list-style-type: none"> ○ <i>Where are students permitted to use smokeless tobacco during regular school hours?</i> ○ <i>Are students permitted to use smokeless tobacco in any of these places during <u>non-school hours</u>?</i>

[Show Handcard #1]

- Looking at Handcard #1, are school staff permitted to smoke in any of these places during regular school hours?

[If yes:]

- Where are school staff permitted to smoke during regular school hours?
- Are school staff permitted to smoke in any of these places during non-school hours?

[Show Handcard #1]

- Looking at Handcard #1, are school staff permitted to use smokeless tobacco in any of these places during regular school hours?

[If yes:]

- Where are school staff permitted to use smokeless tobacco during regular school hours?
- Are school staff permitted to use smokeless tobacco in any of these places during non-school hours?
- Do your smoking and smokeless tobacco policies apply to visitors at your school?

No

Yes, smoking policies apply

Yes, smokeless tobacco policies apply

Expected Periodicity

Periodic.

Comments

SHPPS 2000 tobacco use prevention questions, which will provide the first update for this objective, are different from those used in the 1994 SHPPS. The updated questions, summarized, will include:

- Has this school adopted a policy prohibiting [cigarette smoking/cigar and pipe smoking/smokeless tobacco use] by [students/faculty and staff/school visitors]?
- Does that policy specifically prohibit [cigarette smoking/smokeless tobacco use] by [students/faculty and staff/school visitors]...

In school buildings?

Outside, on school grounds?

In school buses or other vehicles used to transport students?

At off-campus, school-sponsored events?

This objective differs from Healthy People 2000 objective 3.10, which not only tracked school districts providing tobacco-free environments, but also the proportion of school districts providing antismoking education. This objective focuses on smoke- and tobacco-free environments only.

See Part C for a description of SHPPS and Appendix A for focus area contact information.



27-12. Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas.

National Data Sources	1999 National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP) and OPHS, ODPHP.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 3.11 (Tobacco) (also 10.18).
Measure	Percent.
Baseline	79 (1998–99).
Numerator	Number of nongovernmental worksites with 50 or more employees that have a formal smoking policy that prohibits or severely restricts smoking at the worksite or on the job.
Denominator	Number of nongovernmental worksites with 50 or more employees.
Population Targeted	Nongovernmental worksites with 50 or more employees.
Questions Used To Obtain the National Data	From the 1999 National Worksite Health Promotion Survey: ➤ <i>Does your worksite have a formal smoking policy that prohibits or severely restricts smoking at the worksite/on the job?</i>
Expected Periodicity	Periodic.

Comments

Data for this objective are not comparable to the data for Healthy People 2000 objective 3.11 from the 1992 National Survey of Worksite Health Promotion Activities. The 1992 questionnaire had a more explicit list of questions to determine the type of formal smoking policy.

The 1999 question was similar to the 1992 question: Does your worksite have a formal smoking policy that prohibits or severely restricts smoking at the workplace? In 1992, if the answer was “yes,” the respondent was asked: “How would you describe the rules on smoking at the worksite? Possible responses were: (a) Smoking not allowed anywhere inside/smoke-free environment, (b) Smoking not allowed except in separately ventilated smoking areas, (c) Smoking not allowed except in designated areas without separate ventilation, (d) Smoking allowed everywhere except in a few no smoking areas, (e) Each area decides on its own policy, (f) Smoking permitted everywhere/no rules, (g) Designated areas, ventilation unknown, (h) Other.

See Part C for a description of NWHPS and Appendix A for focus area contact information.



27-13. Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in public places and worksites.

27-13a. Private workplaces.

National Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
State Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
Healthy People 2000 Objective	3.12 (Tobacco) (also 10.19).
Measure	Number.
Baseline	1 (1998).

Numerator	Number of States and the District of Columbia with comprehensive laws for private workplaces prohibiting smoking or limiting it to separately ventilated areas.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Quarterly.
Comments	<p>Every 3 months (March 31, June 30, September 30, December 31), newly enacted State tobacco-control legislation is downloaded from Lexis-Nexis, an on-line legal database. CDC, OSH searches two Lexis-Nexis subfiles: the StateTrack System and the Advanced Legislative Services System. The downloads are coded according to variables identified by CDC, OSH, which include the comprehensiveness of the law, includes smoking areas permitted or required, separately ventilated smoking areas required, and no smoking allowed. In some cases, data on enforcement authority, penalty for violation, and signage required are also collected.</p> <p>See Part C for a description of the STATE System and Appendix A for focus area contact information.</p>



27-13b. Public workplaces.

National Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
State Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
Healthy People 2000 Objective	3.12 (Tobacco) (also 10.19).
Measure	Number.
Baseline	13 (1998).
Numerator	Number of States and the District of Columbia with comprehensive laws for public workplaces prohibiting smoking or limiting it to separately ventilated areas.

Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Quarterly.
Comments	See Comments provided with objective 27-13a for more information.



27-13c. Restaurants.

National Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
State Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
Healthy People 2000 Objective	3.12 (Tobacco) (also 10.19).
Measure	Number.
Baseline	3 (1998).
Numerator	Number of States and the District of Columbia with comprehensive laws for restaurants prohibiting smoking or limiting it to separately ventilated areas.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Quarterly.
Comments	See Comments provided with objective 27-13a for more information.



27-13d. Public transportation.

National Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
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State Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
Healthy People 2000 Objective	3.12 (Tobacco) (also 10.19).
Measure	Number.
Baseline	16 (1998).
Numerator	Number of States and the District of Columbia with comprehensive laws for public transportation prohibiting smoking or limiting it to separately ventilated areas.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Quarterly.
Comments	For this objective, data on enforcement authority, penalty for violation, and signage required are not currently included in the STATE System. See Comments provided with objective 27-13a for more information.



27-13e. Day care centers.

National Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
State Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
Healthy People 2000 Objective	3.12 (Tobacco) (also 10.19).
Measure	Number.
Baseline	22 (1998).
Numerator	Number of States and the District of Columbia with comprehensive laws for day care centers (commercial or home-based) prohibiting smoking or limiting it to separately ventilated areas.
Denominator	Not applicable.

Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Quarterly.
Comments	Commercial and home-based day care centers are tracked separately; this objective combines them. See Comments provided with objective 27-13a for more information.



27-13f. Retail stores.

National Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
State Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
Healthy People 2000 Objective	Adapted from 3.12 (Tobacco) (also 10.19).
Measure	Number.
Baseline	4 (1998).
Numerator	Number of States and the District of Columbia with comprehensive laws for malls and grocery stores prohibiting smoking or limiting it to separately ventilated areas.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Quarterly.
Comments	<p>Retail stores, as a general category, are not tracked. Measures are only available for malls and grocery stores. Data on enforcement authority, penalty for violation, and signage required are not currently included in the STATE System for this objective.</p> <p>This objective differs from Healthy People 2000 objective 3.12, which did not specifically track retail stores.</p>

See Comments provided with objective 27-13a for more information.



27-13g. (Developmental) Tribes.

Comments	An operational definition could not be specified at the time of publication. See Appendix A for focus area contact information.
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27-13h. (Developmental) Territories.

Comments	An operational definition could not be specified at the time of publication. A proposed data source is Lexis-Nexis, an online legal database. CDC searches two Lexis-Nexis subfiles: the StateTrack system and the Advanced Legislative Services system. As data become available, some U.S. territories may also be tracked. See Appendix A for focus area contact information.
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Social and Environmental Changes

27-14. Reduce the illegal sales rate to minors through enforcement of laws that prohibit such sales.

27-14a. States and the District of Columbia.

National Data Source	State Synar Enforcement Reporting, SAMHSA, CSAP.
State Data Source	State Synar Enforcement Reporting, SAMHSA, CSAP.
Healthy People 2000 Objective	Adapted from 3.13 (Tobacco).
Measure	Number.

Baseline	0 (1998).
Numerator	Number of States and the District of Columbia with a 5 percent or less illegal sales rate to minors in compliance checks.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>As required by the Synar Amendment, all 50 States and the District of Columbia submit their baseline sales rates in compliance checks to SAMHSA as part of their annual Substance Abuse Prevention and Treatment (SAPT) block grant applications.</p> <p>This objective is defined differently from Healthy People 2000 objective 3.13, which targets States and the District of Columbia that have a 20 percent or less illegal buy rate among minors.</p> <p>See Appendix A for focus area contact information.</p>



27-14b. Territories.

National Data Source	State Synar Enforcement Reporting, SAMHSA, CSAP.
State Data Source	State Synar Enforcement Reporting, SAMHSA, CSAP.
Healthy People 2000 Objective	Adapted from 3.13 (Tobacco).
Measure	Number.
Baseline	0 (1998).
Numerator	Number of U.S. territories with a 5-percent or less illegal buy rate among minors in compliance checks.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.

Expected Periodicity	Annual.
Comments	<p>U.S. territories eligible for inclusion are: American Samoa, Guam, Marshall Islands, Federated States of Micronesia, Commonwealth of the Northern Mariana Islands, Republic of Palau, Puerto Rico, and the Virgin Islands.</p> <p>This objective differs from Healthy People 2000 objective 3.13, which did not target U.S. territories.</p> <p>See Comments provided with objective 27-14a for more information.</p> <p>See Appendix A for focus area contact information.</p>



27-15. Increase the number of States and the District of Columbia that suspend or revoke State retail licenses for violations of laws prohibiting the sale of tobacco to minors.

National Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
State Data Source	State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.
Healthy People 2000 Objective	Not applicable.
Measure	Number.
Baseline	34 (1998).
Numerator	Number of States and the District of Columbia with minors' access laws with provisions for license suspension and/or revocation for violation.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Quarterly.

Comments	<p>Every 3 months (March 31, June 30, September 30, December 31), newly enacted State tobacco-control legislation is downloaded from Lexis-Nexis, an on-line legal database. CDC, OSH searches two Lexis-Nexis subfiles: the State Track System and the Advanced Legislative Services System. The downloads are coded according to variables identified by CDC, OSH, which include the comprehensiveness of the law, that is, minimum age for legal sale, inclusion of chewing tobacco and/or snuff, enforcement authority, penalty for violation, prohibition of purchase, possession and/or use by minors, etc.</p> <p>See Part C for a description of the STATE System and Appendix A for focus area contact information.</p>
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27-16. (Developmental) Eliminate tobacco advertising and promotions that influence adolescents and young adults.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>Proposed national data sources are the American Legacy Foundation and the National Association of Attorneys General.</p> <p>See Appendix A for focus area contact information.</p>
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27-17. Increase adolescents' disapproval of smoking.

27-17a. 8th grade.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.9 (Substance Abuse: Alcohol and Other Drugs) (also 3.21).
Measure	Percent.

Baseline	80 (1998).
Numerator	Number of students in the 8th grade who disapprove or strongly disapprove of people smoking one or more packs of cigarettes per day.
Denominator	Number of students in the 8th grade.
Population Targeted	Public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	From the 1998 Monitoring the Future Study:

- *Individuals differ in whether or not they disapprove of people doing certain things. Do YOU disapprove of people doing each of the following:*

[Response categories include:]

Smoking one or more packs of cigarettes per day?

Don't disapprove

Disapprove

Strongly disapprove

Can't say, Drug Unfamiliar

Expected Periodicity	Annual.
Comments	<p>This objective differs from Healthy People 2000 objective 4.9, which tracked high school seniors only.</p> <p>See Part C for a description of the MTF and Appendix A for focus area contact information.</p>



27-17b. 10th grade.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	Adapted from 4.9 (Substance Abuse: Alcohol and Other Drugs) (also 3.21).
Measure	Percent.
Baseline	75 (1998).
Numerator	Number of students in the 10th grade who disapprove or strongly disapprove of people smoking one or more packs of cigarettes per day.
Denominator	Number of students in the 10th grade.

Population Targeted	Public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	<p>From the 1998 Monitoring the Future Study:</p> <p>➤ <i>Individuals differ in whether or not they disapprove of people doing certain things. Do YOU disapprove of people doing each of the following:</i></p> <p>[Response categories include:]</p> <p><i>Smoking one or more packs of cigarettes per day?</i></p> <p><i>Don't disapprove</i></p> <p><i>Disapprove</i></p> <p><i>Strongly disapprove</i></p> <p><i>Can't say, drug unfamiliar</i></p>
Expected Periodicity	Annual.
Comments	<p>This objective differs from Healthy People 2000 objective 4.9, which tracked high school seniors only.</p> <p>See Part C for a description of MTF and Appendix A for focus area contact information.</p>



27-17c. 12th grade.

National Data Source	Monitoring the Future Study (MTF), NIH, NIDA.
State Data Source	Not identified.
Healthy People 2000 Objective	4.9 (Substance Abuse: Alcohol and Other Drugs) (also 3.21).
Measure	Percent.
Baseline	69 (1998).
Numerator	Number of students in the 12th grade who disapprove or strongly disapprove of people smoking one or more packs of cigarettes per day.
Denominator	Number of students in the 12th grade.
Population Targeted	Public and private schools in the coterminous United States.
Questions Used To Obtain the National Data	From the 1998 Monitoring the Future Study:

- *Individuals differ in whether or not they disapprove of people doing certain things. Do YOU disapprove of people (who are 18 or older) doing each of the following? (Mark one circle for each line.)*

[Response categories include:]

Smoking one or more packs of cigarettes per day?

Don't disapprove

Disapprove

Strongly disapprove

Expected Periodicity

Annual.

Comments

Refer to Part for a description of MTF and Appendix A for focus area contact information.



27-18. (Developmental) Increase the number of Tribes, territories, and States and the District of Columbia with comprehensive, evidence-based tobacco control programs.

Comments

An operational definition could not be specified at the time of publication.

A proposed data source is the State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH; for Tribes, a proposed data source is the IHS.

See Appendix A for focus area contact information.



27-19. Eliminate laws that preempt stronger tobacco control laws.

National Data Source

State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

State Data Source

State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

Healthy People 2000 Objective

Adapted from 10.20 (Occupational Safety and Health) (also 3.25).

Measure

Number.

Baseline

30 (1998).

Numerator	Number of States and the District of Columbia with preemptive laws in the areas of clean indoor air, minors' access, or marketing.
Denominator	Not applicable.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Quarterly.
Comments	<p>Every 3 months (March 31, June 30, September 30, December 31), newly enacted State tobacco-control legislation is downloaded from Lexis-Nexis, an on-line legal database. CDC, OSH searches two Lexis-Nexis subfiles: the StateTrack System and the Advanced Legislative Services System. The downloads are coded according to variables identified by CDC, OSH, which include preemption related to smoke-free indoor air, minors' access, and marketing. As data become available, some U.S. territories may also be tracked.</p> <p>This objective differs from Healthy People 2000 objective 3.25, which tracked States and the District of Columbia that had preemptive laws regarding smoke-free indoor air only.</p> <p>See Part C for a description of the STATE System and Appendix A for focus area contact information.</p>



27-20. (Developmental) Reduce the toxicity of tobacco products by establishing a regulatory structure to monitor toxicity.

Comments	<p>An operational definition could not be specified at the time of publication. A proposed national data source is the Food and Drug Administration.</p> <p>See Appendix A for focus area contact information.</p>
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27-21. Increase the average Federal and State tax on tobacco products.

27-21a. Cigarettes.

National Data Source	The Tax Burden on Tobacco, ¹ The Tobacco Institute.
State Data Source	The Tax Burden on Tobacco, ¹ The Tobacco Institute.
Healthy People 2000 Objective	Adapted from 3.23 (Tobacco).
Measure	Mean.
Baseline	\$0.63 (1998).
Numerator	Sum of the State excise taxes on the retail price of a package of 20 cigarettes (full-priced brands) in all 50 States and the District of Columbia.
Denominator	All 50 States and the District of Columbia.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Quarterly.
Comments	<p>The State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH, is proposed as a future data source for this objective.</p> <p>This objective is modified from Healthy People 2000 objective 3.23, which tracks tobacco excise tax by percent of the retail price.</p> <p>See Appendix A for focus area contact information.</p>



27-21b. (Developmental) Spit tobacco.

Comments	<p>An operational definition could not be specified at the time of publication.</p> <p>Federal tax in 1999 was 2.7 cents; 7 States and the District of Columbia did not tax smokeless tobacco products.</p>
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A proposed data source is the State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

This objective is modified from Healthy People 2000 objective 3.23 (Tobacco).

See Appendix A for focus area contact information.



Reference

1. The Tobacco Institute. *The Tax Burden on Tobacco*. Vol. 33. Washington, DC: the Institute, 1998.

28

Vision and Hearing

Vision

- 28-1 Dilated eye examinations
- 28-2 Vision screening for children
- 28-3 Impairment due to refractive errors
- 28-4 Impairment in children and adolescents
- 28-5 Impairment due to diabetic retinopathy
- 28-6 Impairment due to glaucoma
- 28-7 Impairment due to cataract
- 28-8 Occupational eye injury
- 28-9 Protective eyewear
- 28-10 Vision rehabilitation services and devices
 - 28-10a Rehabilitation services
 - 28-10b Visual and adaptive devices

Hearing

- 28-11 Newborn hearing screening, evaluation, and intervention
- 28-12 Otitis media
- 28-13 Rehabilitation for hearing impairment
- 28-14 Hearing examination
- 28-15 Evaluation and treatment referrals
- 28-16 Hearing protection
- 28-17 Noise-induced hearing loss in children
- 28-18 Noise-induced hearing loss in adults

Vision

28-1. (Developmental) Increase the proportion of persons who have a dilated eye examination at appropriate intervals.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

A proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



28-2. (Developmental) Increase the proportion of preschool children aged 5 years and under who receive vision screening.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

See Part C for a description of NHIS and Appendix A for focus area contact information.



28-3. (Developmental) Reduce uncorrected visual impairment due to refractive errors.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

See Part C for a description of NHANES and Appendix A for focus area contact information.



28-4. Reduce blindness and visual impairment in children and adolescents aged 17 years and under.

National Data Source	National Health Interview Survey (NHIS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population.
Baseline	25 (1997).
Numerator	Number of children and adolescents aged 17 years and under who have trouble seeing, even when wearing glasses or contact lenses.
Denominator	Number of children and adolescents aged 17 years and under.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	From the 1997 National Health Interview Survey: ➤ <i>Does—have any trouble seeing?</i> <i>(If age 2+ years:) even when wearing glasses or focus area contact lenses?</i>
Expected Periodicity	Annual.
Comments	See Part C for a description of NHIS and Appendix A for focus area contact information.



28-5. (Developmental) Reduce visual impairment due to diabetic retinopathy.

Comments	An operational definition could not be specified at the time of publication.
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A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

A proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

Diabetic retinopathy is a complication of diabetes that damages the retina and is a major cause of blindness among people with diabetes.

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



28-6. (Developmental) Reduce visual impairment due to glaucoma.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

From the 1999 NHIS, the proposed question used to obtain the national data is:

- *Have you EVER been told by a doctor or other health professional that you had glaucoma?*

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



28-7. (Developmental) Reduce visual impairment due to cataract.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed State data source is the Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

From the 1999 NHIS, the proposed question to obtain the national data is:

- *These next questions are about your eyesight. Do you now have cataracts?*

Cataract is classified as a cloudiness of the lens that may prevent a clear image from forming on the retina.

See Part C for a description of NHIS and BRFSS and Appendix A for focus area contact information.



28-8. (Developmental) Reduce occupational eye injury.

Comments

An operational definition could not be specified at the time of publication.

Proposed national data sources are the Annual Survey of Occupational Injuries and Illnesses (ASOII), DOL, BLS and the National Electronic Injury Surveillance System (NEISS), CPSC, and NIOSH.

See Appendix A for focus area contact information.



28-9. (Developmental) Increase the use of appropriate personal protective eyewear in recreational activities and hazardous situations around the home.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

Recreational activities include baseball, basketball, tennis, racquetball, and hockey.

Hazardous situations around the home include cooking and yard work.

See Part C for a description of NHIS and Appendix A for focus area contact information.



28-10. (Developmental) Increase the use of vision rehabilitation services and visual and adaptive devices by people with visual impairments.

28-10a. Increase the use of rehabilitation services by persons with visual impairments.

Comments An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

See Appendix A for focus area contact information.



28-10b. Increase the use of visual and adaptive devices by persons with visual impairments.

Comments An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

See Appendix A for focus area contact information.



Hearing

28-11. (Developmental) Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months.

Comments An operational definition could not be specified at the time of publication.

A proposed data source is the State-based Early Hearing Detection and Intervention (EHDI) Program Network, CDC.

See Part C for a description of NHIS and Appendix A for focus area contact information.



28-12. Reduce otitis media in children and adolescents.

National Data Sources	National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS.
State Data Source	Not identified.
Healthy People 2000 Objective	Not applicable.
Measure	Rate per 1,000 population.
Baseline	344.7 (1997).
Numerator	Number of visits to ambulatory care facilities with a diagnosis of otitis media (any mention of ICD-9-CM codes 381.0-381.4, 382) among children and adolescents aged 17 years and under.
Denominator	Number of children and adolescents aged 17 years and under.
Population Targeted	U.S. civilian, noninstitutionalized population.
Questions Used To Obtain the National Data	Not applicable.
Expected Periodicity	Annual.
Comments	<p>The number of otitis media visits to ambulatory care facilities obtained from NAMCS are added to the number of visits obtained from NHAMCS.</p> <p>Otitis media, commonly called ear infection, is an inflammation of the middle ear caused by viral or bacterial infection.</p> <p>Ambulatory care facilities include physicians' offices, hospital emergency departments and outpatient departments.</p>

See Part C for a description of NAMCS and NHAMCS and Appendix A for focus area contact information.



28-13. (Developmental) Increase access by persons who have hearing impairments to hearing rehabilitation services and adaptive devices, including hearing aids, cochlear implants, or tactile or other assistive or augmentative devices.

Comments

An operational definition could not be specified at the time of publication.

The proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed questions to obtain the national data will be included in the 2001 NHIS.

Rehabilitation services are those services that address the needs in daily living skills that are directly related to hearing loss.

Adaptive devices include large-print materials (books, newspaper), check-writing guides, high-contrast watch dials, and auditory aids, such as talking computers.

A hearing aid is an electronic device that brings amplified sound to the ear, usually consisting of a microphone, amplifier, and receiver.

Cochlear implant is a medical device that bypasses damaged structures in the inner ear and directly stimulates the auditory nerve, allowing some deaf individuals to hear and to maintain or develop speech and language.

Tactile devices are mechanical instruments that make use of touch to help individuals to communicate who have certain disabilities, such as deafness and blindness.

Assistive devices are technical tools and devices used to aid individuals who have communication disorders in performing actions, tasks, and activities. Examples include alphabet boards, text telephones (TT/TTY/TTD), and text-to-speech conversion software. (See Focus Area 6. Disability and Secondary Conditions.)

See Part C for a description of NHIS and Appendix A for focus area contact information.



28-14. (Developmental) Increase the proportion of persons who have had a hearing examination on schedule.

Comments

An operational definition could not be specified at the time of publication.

Proposed national data sources are the National Health Interview Survey (NHIS), CDC, NCHS, and the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

The proposed questions to obtain the national data will be included in the 2001 NHIS.

See Part C for a description of NHIS, NHANES, and Appendix A for focus area contact information.



28-15. (Developmental) Increase the number of persons who are referred by their primary care physician for hearing evaluation and treatment.

Comments

An operational definition could not be specified at the time of publication.

Proposed national data sources are the National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS, and the National Health Interview Survey (NHIS), CDC, NCHS.

See Part C for a description of NAMCS and Appendix A for focus area contact information.



28-16. (Developmental) Increase the use of appropriate ear protection devices, equipment, and practices.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health Interview Survey (NHIS), CDC, NCHS.

The proposed questions to obtain the national data will be included in the 2001 NHIS.

See Part C for a description of NHIS and Appendix A for focus area contact information.



28-17. (Developmental) Reduce noise-induced hearing loss in children and adolescents aged 17 years and under.

Comments

An operational definition could not be specified at the time of publication.

A proposed national data source is the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

Noise-induced hearing loss is caused by either a one-time exposure to very loud sound(s) or by repeated exposure to sounds at various loudness levels over an extended period of time. Hearing loss may be temporary or permanent.

See Part C for a description of NHANES and Appendix A for focus area contact information.



28-18. (Developmental) Reduce adult hearing loss in the noise-exposed public.

Comments

An operational definition could not be specified at the time of the publication.

Proposed national data sources are the National Health Interview Survey (NHIS), CDC, NCHS and the National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

Proposed questions used to obtain the national data will be included in the 2001 NHIS.

Hearing loss for adults aged 20 to 69 years is determined from a hearing test conducted in each ear at 500, 1000, 2000, 3000, 4000, 6000, and 8000 Hz.

See Part C for a description of NHIS and Appendix A for focus area contact information.



Part C: Major Data Sources for Healthy People 2010

The 467 Healthy People 2010 objectives are being tracked by 190 data sources. A major data source is defined as a data system responsible for tracking five or more Healthy People 2010 objectives. There are 23 data systems that meet these criteria. A brief discussion of each (in alphabetical order) is provided in this section. Table 7 (below) lists the major data sources by the number of objectives they track. More than three-fifths (286) of the objectives are tracked with data from these sources.

Table 7
Number of Objectives Tracked by Healthy People
2010 Major Data Sources

Data Sources	Number of Objectives Tracked
National Health Interview Survey (NHIS)	67
National Health and Nutrition Examination Survey (NHANES)	35
National Vital Statistics System—Mortality (NVSS-M)	32
National Survey of Family Growth (NSFG)	14
National Hospital Discharge Survey (NHDS)	11
Youth Risk Behavior Surveillance System (YRBSS)	11
HIV/AIDS Surveillance System	10
Behavioral Risk Factor Surveillance System (BRFSS)	9
National Household Survey on Drug Abuse (NHSDA)	8
School Health Policies and Programs Study (SHPPS)	8
National Vital Statistics System—Nativity (NVSS-N)	8
National Profile of Local Health Departments (NPLHD)	8
National Ambulatory Medical Care Survey (NAMCS)	7
United States Renal Data System (USRDS)	7
STD Surveillance System (STDSS)	7
Medical Expenditure Panel Survey (MEPS)	6
National Hospital Ambulatory Medical Care Survey (NHAMCS)	6
Continuing Survey of Food Intake by Individuals (CSFII)	6
National Crime Victimization Survey (NCVS)	6
1999 National Worksite Health Promotion Survey (NWHPS)	5
State Tobacco Activities Tracking and Evaluation System (STATES)	
National Notifiable Disease Surveillance System (NNDSS)	5
Monitoring the Future Study (MTF)	5

Behavioral Risk Factor Surveillance System (BRFSS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).
Mode of Administration	Telephone interview.
Survey Sample Design	Data collection is conducted separately by each State. Sample design uses State-level, random-digit-dialed probability samples of the adult (aged 18 years and over) population. Most States currently use disproportionate random sampling methods. Increasing State participation over time, with 15 States in 1984 and all 50 States and the District of Columbia since 1994. In 1998, State-specific sample sizes ranged from 1,499 to 6,005. The median sample size was 2,648.
Response Rates	State response rates vary from year to year. In 1998, upper-bound response rates ranged from 45 to 95 percent (median response rate: 73 percent).
Primary Survey Content	The survey consists of a core of questions asked in all States, standardized optional questions on selected topics that are administered at the State's discretion, a rotating core of questions asked every other year in all States, and State-added questions developed to address State-specific needs. Questions cover behavioral risk factors (for example, alcohol and tobacco use), preventive health measures, HIV/AIDS, health status, limitation of activity, and health care access and utilization.
Population Targeted	Civilian, noninstitutionalized population 18 years of age and older who reside in households with telephones.
Demographic Data	Gender, age, educational attainment, race/ethnicity, household income, employment status, and marital status.
Years Collected	Annually since 1984.
Schedule	Annual.
Geographic Estimates	National; State; smaller area estimates possible in some States.
Notes	The BRFSS is a partnership between State Health Departments and CDC; CDC provides about one-half of the financial resources for States to use for data collection efforts. States have substantial input on questions used by all States through the BRFSS. Many Healthy People objectives are tracked with questions that are asked every other year or are optional. Persons who do not have telephones or have telephones but are either in institutional settings or cannot be understood over the telephone are excluded.

Behavioral Risk Factor Surveillance System (BRFSS)

Contact Information

Data system homepage:

<http://www.cdc.gov/nccdphp/brfss>

Data system phone: 770-488-2455

Agency homepage:

<http://www.cdc.gov/nccdphp>

Agency phone: 770-488-5401

References

Centers for Disease Control and Prevention. *The Behavioral Risk Factor Surveillance System User's Guide*. Atlanta, GA: U.S. Department of Health and Human Services, 1998.

Nelson, D.E.; Holtzman, D.; Waller, M.; et al. Objectives and design of the Behavioral Risk Factor Surveillance System. *American Statistical Association 1998 Proceedings of the Section on Survey Research Methods*. Alexandria, VA: American Statistical Association (ASA), 1998, 214-218.

Powell-Griner, E. Uses and limitations of the Behavioral Risk Factor Surveillance System data. *American Statistical Association 1998 Proceedings of the Section on Survey Research Methods*. Alexandria, VA: ASA, 1998, 219-223.

Continuing Survey of Food Intake by Individuals (CSFII), 1994–96

Sponsor	U.S. Department of Agriculture (USDA), Agricultural Research Service (ARS).
Mode of Administration	Two nonconsecutive days of food intake data collected 3-10 days apart during in-person interviews using the 24-hour dietary recall method. About 2 weeks later, one adult from each household was asked to answer a series of questions about knowledge and attitudes toward dietary guidance, health, and use of food labels.
Survey Sample Design	Nationally representative stratified multistage area probability sample of U.S. noninstitutionalized civilian population, all ages. Subsampling of individuals in households. Oversampling of low-income households with incomes at or below 130 percent of the poverty threshold. For 1994–96, sample size for 1-day dietary data was 16,103; for 2-day dietary data, it was 15,303.
Response Rates	One-day response rate: 80 percent; and 2-day response rate: 76 percent.
Primary Survey Content	Kinds and amounts of foods consumed on each of 2 nonconsecutive days, sources of foods, time, name of each eating occasion. Also collected are food expenditures, shopping practices, pregnancy, lactation, nursing status, and height and weight.
Population Targeted	The civilian, noninstitutionalized population residing in all 50 States and the District of Columbia, all ages.
Demographic Data	Household: Income, poverty status, household size, region, urbanization, tenancy, participation in Food Stamp and WIC programs. Individual: Gender, age, education, race, ethnicity (Hispanic or non-Hispanic), employment status of persons 15 years of age and older.
Years Collected	1994–96.
Schedule	Periodic.
Geographic Estimates	National; four U.S. Census Bureau regions; Standard Metropolitan Statistical Areas.

Continuing Survey of Food Intake by Individuals (CSFII), 1994–96

Notes	<p>Additional outcome variables: For each of 2 days of intake and 2-day averages, food intakes in grams of 71 USDA-defined food groups and subgroups, nutrient intakes of 28 nutrients and food components, nutrient intakes expressed as percentages of the 1989 Recommended Dietary Allowances, and Pyramid servings from 30 food groups. Various components of the dietary collection methodology will change from the 1994–96 survey to the next survey planned for the year 2000. Two 24-hour recalls will be collected by telephone instead of by in-person interview. Further research will assess the impact of the changes in dietary data collection methods on the comparability of the 1994–96 and the 2000 survey estimates.</p>
Contact Information	<p>Data system homepage: http://www.barc.usda.gov/bhnrc/foodsurvey/home.htm</p> <p>Data system phone: 301-504-0170</p> <p>Agency homepage: http://www.usda.gov</p> <p>Agency phone: 202-720-2791</p>
References	<p>Ingwersen, L.A.; Haggerty, E.S.; LaComb, R.P.; et al. Continuing Survey of Food Intakes by Individuals (CSFII) Methodology: Translating Food Intakes into Data. Champagne, C., ed. <i>21st National Nutrient Databank Conference Proceedings</i>. Baton Rouge, LA, 1998.</p> <p>Mickle, S.J.; Vecchio, F.A.; and Guenther, P.M. Recent and Current Continuing Survey of Food Intakes by Individuals (CSFII) Methodology Research. Champagne, C., ed. <i>21st National Nutrient Databank Conference Proceedings</i>. Baton Rouge, LA, 1998.</p> <p>LaComb, R.P.; Green A.; and Ingwersen, L. Survey Net: Coding and Management of CSFII Food Intake Data. <i>American Statistical Association 1997 Proceedings of the Section on Survey Research Methods</i>. Alexandria, VA: American Statistical Association, 1997.</p> <p>Hama, M.Y. CSFII and HFCS Data: Issues, Problems, and Needs. Emerging Data Issues in Applied Food Demand Analysis. Proceedings of a Workshop Held by the S216, Food Demand and Consumption Behavior Regional Committee, 1993.</p>

HIV/AIDS Surveillance System

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for HIV, STD, and TB Prevention (NCHSTP).
Mode of Administration	Reports from health care providers are sent to the local, State, or territorial health departments. States and territories share, on a voluntary basis, de-identified data with CDC.
Survey Sample Design	All 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and other U.S. territories report AIDS cases.
Response Rates	Response rates vary by geographic region and patient population. In most areas, reporting of AIDS cases is at least 85 percent complete. Reporting of deaths is about 90 percent complete.
Primary Survey Content	The AIDS case definition was modified in 1985, 1987, 1993 (for adults and adolescents), and 1994 (for pediatric cases). Data include mode of exposure to HIV, case definition category, and other clinical and demographic information.
Population Targeted	Entire population of all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and other U.S. territories. AIDS data are nationally representative.
Demographic Data	Age, gender, race, ethnicity, State and county of residence, country of birth, and living status.
Years Collected	CDC first received reports of persons with AIDS in 1981.
Schedule	Biannual. HIV/AIDS Surveillance Report is published twice a year. Supplemental reports are published on an ad hoc basis and available on the Web at http://www.cdc.gov/nchstp/hiv_aids/stats/hasrlink.HTM and at http://www.cdc.gov/nchstp/hiv_aids/pubs/mmwr.htm .
Geographic Estimates	National, State, and Metropolitan Statistical Area. Data release policies dictate that no data that could be used to identify a person reported to the system may be released, thus, release of data in cell sizes less than or equal to three in a given category are prohibited.
Notes	HIV/AIDS case surveillance is a population-based system.
Contact Information	Data system homepage: http://www.cdc.gov/nchstp/hiv_aids/surveillance.htm Data system phone: 404-639-2057 Agency homepage: http://www.cdc.gov/nchstp/od/nchstp.html Agency phone: 770-488-5401

HIV/AIDS Surveillance System

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CDC. *HIV/AIDS Surveillance Report*. Year-end 1998. Vol. 10, No. 2, 1999.

Medical Expenditure Panel Survey (MEPS)

Sponsor	U.S. Department of Health and Human Services: Agency for Healthcare Research and Quality (AHRQ) and Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	<p>The MEPS comprises four linked, integrated surveys, three of which are of interest here:</p> <p>Household Component (HC): Computer-assisted, in-person interviews;</p> <p>Medical Provider Component (MPC): Telephone interviews and mailed surveys; and,</p> <p>Insurance Component (IC): Telephone interviews and mailed surveys.</p>
Survey Sample Design	Each year, the MEPS HC sample is a nationally representative subsample of the National Health Interview Survey (NHIS), which uses a stratified multistage probability design that permits a continuous sampling of 358 primary sampling units. The 1996 HC collected data on 10,500 families and 24,000 individuals who participated in the 1995 NHIS. The MPC bases its sample on the HC. The IC partially bases its sample on the HC. Data are obtained through employers, unions, or other private health insurance sources identified by the HC respondents.
Response Rates	HC: Rate varies by round, so effective response rate varies by reference period of analysis; however, for estimates of calendar year 1996, MEPS has a response rate of 70 percent, including the NHIS and three rounds of data collection. MPC: Rate is over 90 percent. IC: Rate varies by type of establishment; it is over 90 percent for governments and less for employers.
Primary Survey Content	HC: Health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. MPC: Information on medical care events from medical providers identified by HC respondents, including expense information for events covered under various managed care plans. IC: Data on types of health insurance plans, associated premiums, and numbers of plans offered.
Population Targeted	HC: Civilian noninstitutionalized families and individuals, all ages. MPC: Medical providers identified by HC respondents. IC: Health insurance companies.

Medical Expenditure Panel Survey (MEPS)

Demographic Data	Age, race, ethnicity, region, occupation, employment status, and household composition.
Years Collected	1977, 1987, and 1996 to present.
Schedule	Annual.
Geographic Estimates	National. The HC data also can be shown for the four Census regions (Northeast, Midwest, South, and West). Some State information can be provided for the IC.
Notes	AHRQ fields a new MEPS panel each year. In this design, two calendar years of information are collected from each household in a series of five rounds of data collection over a 2 1/2-year period. These data are then linked with additional information collected from the respondents' medical providers, employers, and insurance providers. This series of data collection activities is repeated each year on a new sample of households, resulting in overlapping panels of survey data.
Contact Information	<p>Data system homepage: http://www.meps.ahrq.gov/survey.htm#target2</p> <p>Data system phone: 301-594-1406</p> <p>Agency homepage: http://www.meps.ahrq.gov</p> <p>Agency phone: 301-594-1406</p>
References	<p>Agency for Health Care Policy and Research (AHCPR). <i>Construction of Weights for the 1996 Medical Expenditure Panel Survey Insurance Component List Sample</i>. MEPS Methodology Report No. 8. AHRQ Pub. No. 00-0005. Rockville, MD: AHCPR, 1999.</p> <p>Sommers, J.P. <i>List Sample Design of the 1996 Medical Expenditure Panel Survey Insurance Component</i>. MEPS Methodology Report No. 6 AHRQ Pub. No. 99-0037. Rockville, MD: AHCPR, 1999.</p> <p>Sommers, J.P.; Bethel, J.; and Broene, P. <i>Construction of Weights for the 1996 Medical Expenditure Panel Survey Nursing Home Component</i>. MEPS Methodology Report No. 7. AHRQ Pub. No. 99-0045. Rockville, MD: AHCPR, 1999.</p> <p>Cohen, S.B.; DiGaetano, R.; and Goksel, H. <i>Estimation Procedures in the 1996 Medical Expenditure Panel Survey Household Component</i>. MEPS Methodology Report No. 5. AHRQ Pub. No. 99-0027. Rockville, MD: AHCPR, 1999.</p> <p>AHCPR. <i>Design and Methods of the 1996 Medical Expenditure Panel Survey Nursing Home Component</i>. MEPS Methodology Report 3. AHCPR Pub. No. 98-0041. Rockville, MD: AHCPR, 1998.</p>

Medical Expenditure Panel Survey (MEPS)

AHCPR. *Sample Design of the 1996 Medical Expenditure Panel Survey Nursing Home Component*. MEPS Methodology Report 4. AHCPR Pub. No. 98-0042. Rockville, MD: AHCPR, 1998.

Cohen, J. *Design and Methods of the Medical Expenditure Panel Survey Household Component*. MEPS Methodology Report No. 1. AHCPR Pub. No. 97-0026. Rockville, MD: AHCPR, 1997.

Cohen, S. *Sample Design of the 1996 Medical Expenditure Panel Survey Household Component*. MEPS Methodology Report No. 2. AHCPR Pub. No. 97-0027. Rockville, MD: AHCPR, 1997.

Cohen, J.W.; Monheit, A.C.; Beauregard, K.M.; et al. *The Medical Expenditure Panel Survey: A National Health Information Resource*. Inquiry 33:373-389, 1996/1997. Also available as AHCPR Pub. No. 97-R043. Washington, DC: AHCPR, 1997.

Monitoring the Future Study (MTF)

Sponsor	U.S. Department of Health and Human Services, National Institutes of Health (NIH), National Institute on Drug Abuse (NIDA).
Mode of Administration	Self-administered paper and pencil questionnaire completed by a random sample of 8th, 10th, and 12th graders.
Survey Sample Design	The Monitoring the Future Study utilizes a three-stage probability design that includes primary sampling units (PSUs), schools within PSUs, and students within schools. Up to 350 students per school are selected, either by randomly sampling classrooms or by some other random method that is convenient for the school and judged to be unbiased. Beginning in 1991, national samples of 8th and 10th graders were included. Approximately 50,000 responses are collected annually from all three grades combined.
Response Rates	The 1998 response rate for 8th, 10th, and 12th graders was 88, 87, and 82 percent, respectively.
Primary Survey Content	Cigarette, alcohol, and illicit drug use; attitudes and beliefs regarding drug use; attitudes of significant others regarding drug use; drug exposure and availability; lifestyle values, attitudes, and behaviors; participation in organized activities, leisure time activities, and religion; deviant behavior and victimization; health; college plans; and demographic data. Drug use and related attitudes are the key variables.
Population Targeted	Students in 8th, 10th, and 12th grades from public and private schools in the coterminous United States.
Demographic Data	Gender, race/ethnicity, parental education (used as a proxy for socioeconomic status). Data on sexual orientation are not collected.
Years Collected	1975 through present.
Schedule	Annual.
Geographic Estimates	National, census region, and population density (Large Metropolitan Statistical Areas [MSAs], other MSA, non-MSA).
Notes	To obtain estimates, numerator and denominator data are weighted to reflect differential probabilities of selection at three stages of selection: primary areas (counties or groups of counties) within stratum, schools within primary areas, and students within schools. Final weights are normalized to average unity, thus the numerator and denominator estimates reflect the sample design but not population totals. This weighting scheme allows the estimates to be representative of the population of students in public and private schools in the continental United States.

Monitoring the Future Study (MTF)

Contact Information

Data system homepage:

<http://www.isr.umich.edu/src/mtf/index.html>

Data system phone: Not available

Agency homepage: <http://www.nida.nih.gov>

Agency phone: 301-443-6637

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Monitoring the Future: Questionnaire Responses From the Nation's High School Seniors. Ann Arbor, MI: Institute for Social Research, 1995.

O'Malley, P.M. *The Monitoring the Future Study*. In: Jaffe, J.H., et al., eds. *Encyclopedia of Drugs and Alcohol*. New York, NY: Macmillan, 1995.

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National Ambulatory Medical Care Survey (NAMCS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Field personnel meet with participating physicians and instruct them in survey data collection methods. Physicians are asked to complete 1-page questionnaires on a sample of their office visits during an assigned reporting period.
Survey Sample Design	The NAMCS utilizes a three-stage survey design that involves probability samples of primary sampling units (PSUs), physician practices within PSUs, and patient visits within physician practices. Participating physicians are randomly assigned to a 1-week reporting period during the survey year, and a systematic random sample of patient visits during that period is selected by the physician, using a visit sampling rate that varies by the size of the practice. Sample data are weighted to produce national estimates of office visits. About 2,500 physicians were sampled in 1998 and more than 23,000 survey encounter forms were completed.
Response Rates	The survey response rate has averaged around 70 percent.
Primary Survey Content	Information is obtained on various aspects of office visits, including physician practice characteristics, patient characteristics, and other visit characteristics. The survey form is redesigned every 2 years to address changing health data needs. Among the items collected are patient's age, gender, race, and ethnicity; patient's expressed reason for visiting the physician; place, cause, and intentionality of injury, if any; physician's diagnoses; diagnostic services ordered or provided; therapeutic services; ambulatory surgical procedures performed; medications; providers seen; visit disposition; time spent with physician; and expected source of payment.
Population Targeted	The basic sampling unit is the physician-patient encounter or visit. Visits made to the offices of nonfederally employed, office-based physicians who are classified by the American Medical Association or the American Osteopathic Association as being primarily engaged in direct patient care. The specialties of anesthesiology, pathology, or radiology are not included. Not included are contacts by telephone, visits made outside the physician's office, visits in hospitals or institutional settings, and visits made for administrative purposes only.

National Ambulatory Medical Care Survey (NAMCS)

Demographic Data	Patient's age, gender, race, and ethnicity.
Years Collected	Annual from 1973–81; again in 1985; resumed an annual schedule in 1989.
Schedule	Annual.
Geographic Estimates	National; four regions.
Notes	The NAMCS is a visit-based survey rather than a population-based survey. Therefore, estimates of incidence and prevalence of disease cannot be computed. The survey is cross-sectional in nature. Multiple visits may be made by the same person within the sample.
Contact Information	<p>Data system homepage:</p> <p>http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm</p> <p>Data system phone: 301-458-4600</p> <p>Agency homepage: http://www.cdc.gov/nchs</p> <p>Agency phone: 301-458-INFO (4636)</p>
References	Woodwell, D.A. <i>National Ambulatory Medical Care Survey: 1997 Summary</i> . Advance data from Vital and Health Statistics, No. 305. Hyattsville, MD: National Center for Health Statistics, 1999.

National Crime Victimization Survey (NCVS)

Sponsor	U.S. Department of Justice, Bureau of Justice Statistics, Office of Justice Programs.
Mode of Administration	Interview: With the exception of the first and the fifth of a total of seven interviews, all interviews are done by phone using computer-assisted telephone interviewing (CATI). The first and fifth interviews are personal interviews using computer-assisted personal interviewing (CAPI).
Survey Sample Design	The NCVS uses a stratified, multistage cluster sample. Primary sampling units (PSUs) consist of counties, groups of counties, or large metropolitan areas. The 1994 survey sample households were drawn from the 1980-based sample design. Data are collected every year from a sample of approximately 50,000 households that includes about 100,000 people aged 12 years and older. PSUs remain in the sample for a total of 3 years. A total of seven interviews are conducted at 6-month intervals during the 3-year process.
Response Rates	Response rates have consistently remained around 95 percent (96 percent of eligible housing units and 92 percent of individuals in interviewed households).
Primary Survey Content	The NCVS counts incidents not reported to police and is one of two U.S. Department of Justice measures of crime in the United States. The survey contains a screening section with detailed questions and cues on victimizations and situations within which crimes may take place. Interviewers follow up positive responses and collect details about victimizations in incident reports.
Population Targeted	Noninstitutionalized population aged 12 years and older residing in the United States.
Demographic Data	Age, gender, race, ethnicity, and income. Property crimes include data on age, race, ethnicity, and household size.
Years Collected	1974 to present.
Schedule	Annual.
Geographic Estimates	National.
Contact Information	Data system homepage: http://www.oip.usdoj.gov/bjs/cvict.htm#ncvs Data system phone: 202-616-3494 Agency homepage: http://www.oip.usdoj.gov/bjs Agency phone: 202-307-0770

National Crime Victimization Survey (NCVS)

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National Health and Nutrition Examination Survey (NHANES)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	In-person interview in the household and in a private setting in the mobile examination center. Standardized physical examinations and medical tests in mobile examination centers. Conducted in English and Spanish.
Survey Sample Design	The NHANES uses a stratified multistage probability sample, nationally representative of the U.S. civilian noninstitutionalized population. Approximately 5,000 people are examined at 15 locations each year. In NHANES III, children aged 2 months to 5 years, persons aged 70 years and over, African Americans, and Mexican Americans were oversampled. Beginning in 1999, African Americans, Mexican Americans, adolescents, and older persons will be oversampled.
Response Rates	In NHANES III (1988–94): Household interview response rate was 86 percent; and the medical examination response rate was 78 percent.
Primary Survey Content	Chronic disease prevalence and conditions (including undiagnosed conditions), risk factors, diet and nutritional status, immunization status, infectious disease prevalence, health insurance, and measures of environmental exposures. Other topics addressed include hearing, vision, mental health, anemia, diabetes, cardiovascular disease, osteoporosis, obesity, oral health, mental health, and physical fitness. Beginning in 1999, new topics are cardiorespiratory fitness, physical functioning, lower extremity disease, full body DXA for body fat as well as bone density, and tuberculosis infection.
Population Targeted	For NHANES III, the civilian noninstitutionalized population residing in the United States aged 2 months and over. Beginning in 1999, people of all ages are included.
Demographic Data	Gender, age, education, race/ethnicity, place of birth, income, occupation, and industry.
Years Collected	From 1960 to 1994, a total of seven national examination surveys have been conducted. Beginning in 1999, the survey has been conducted continuously.
Schedule	Periodic (1960–94); annual beginning in 1999.
Geographic Estimates	National; four U.S. Census Bureau regions.

Notes	Although the new NHANES will be conducted on a yearly basis, the annual sample size will be too small to provide reliable estimates for many measures and for most subgroups. Most analyses will require 3 years of data for reliable estimates.
Contact Information	<p>Data system homepage: http://www.cdc.gov/nchs/nhanes.htm</p> <p>Data system phone: 301-458-4667</p> <p>Agency homepage: http://www.cdc.gov/nchs</p> <p>Agency phone: 301-458-INFO (4636)</p>
References	<p>National Center for Health Statistics. Plan and operation of the third National Health and Nutrition Examination Survey, 1988–94. National Center for Health Statistics (NCHS). <i>Vital and Health Statistics</i> 1(32), 1994.</p> <p>Ezzati, T.M.; Massey, J.T.; Waksberg, J.; et al. Sample design: Third National Health and Nutrition Examination Survey. NCHS. <i>Vital and Health Statistics</i> 2(113), 1992.</p> <p>Maurer, K.R. Plan and operation of the Hispanic Health and Nutrition Examination Survey, 1982–84. NCHS. <i>Vital and Health Statistics</i> 1(19), 1985.</p>

National Health Interview Survey (NHIS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Personal interview in households using computer-assisted personal interviewing (CAPI), administered by professional interviewers, and conducted in English and Spanish (for CAPI, Spanish version was initiated in mid-1998).
Survey Sample Design	The NHIS uses a stratified multistage probability design that permits a continuous sampling of 358 primary sampling units (PSUs), with over-sampling of African Americans and Hispanics. A typical NHIS sample for the data collection years 1995–2004 consists of approximately 7,000 second-stage units (segments) within a PSU. The expected sample of 43,000 occupied respondent households yields a probability sample of about 111,000 persons. The survey is designed so that the sample scheduled for each week is representative of the target population and the weekly samples are additive over time.
Response Rates	Response rates for the basic NHIS core questionnaire have ranged from 91 to 96 percent over the years, with rates of sample person components generally ranging from 85 to 90 percent of eligible respondents. Response rates for special health topics (supplements) have generally also been in this lower range. The effect, if any, of the new CAPI technology is not yet known.
Primary Survey Content	Information is obtained on demographic characteristics, illnesses, injuries, impairments, chronic conditions, utilization of health resources, health insurance, and other health topics. The core household interview asks about everyone in the household. Additional questions are asked of one sample adult and one sample child (under 18 years) per family in the household. The sample adult questionnaire includes chronic health conditions and limitations in activity, health behaviors, health care access, health care provider contacts, immunizations, and AIDS knowledge and attitudes. The sample child questionnaire includes questions about chronic health conditions, limitation of activities, health status, behavior problems, health care access and utilization, and immunizations. Child data are proxy-reported by a parent or other knowledgeable adult respondent. Adult sample person data are all self-reported. Special modules are fielded periodically, and cover areas such as cancer, prevention, and disability.
Population Targeted	Civilian noninstitutionalized population residing in the United States, all ages.

National Health Interview Survey (NHIS)

Demographic Data	Gender, age, race/Hispanic ethnicity, education, income, marital status, place of birth, industry, and occupation.
Years Collected	Continuously since 1957. Current sample design began in 1995; current questionnaire design began in 1997.
Schedule	Annual.
Geographic Estimates	National; four U.S. Census Bureau regions; some of the 10 HHS regions, some States; metropolitan and nonmetropolitan areas.
Contact Information	Data system homepage: http://www.cdc.gov/nchs/nhis.htm Data system phone: 301-458-4001 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-INFO (4636)
References	Hendershot, G.; Adams, P.; Marano, M.; et al. Current estimates from the National Health Interview Survey, 1996. National Center for Health Statistics (NCHS). <i>Vital and Health Statistics</i> 10(200), 1999. Questionnaires from the National Health Interview Survey, 1985–89. NCHS. <i>Vital and Health Statistics</i> 1(31), 1993. Massey, J.T.; Moore, T.F.; Parsons, V.L.; et al. Design and estimation for the National Health Interview Survey, 1985–94. NCHS. <i>Vital and Health Statistics</i> 2(110), 1989.

National Hospital Ambulatory Medical Care Survey (NHAMCS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Hospital staff are asked to complete one-page questionnaires (Patient Record forms) on a sample of their patient visits during an assigned reporting period.
Survey Sample Design	The NHAMCS utilizes a four-stage probability design that involves samples of primary sampling units (PSUs), hospitals within PSUs, clinics within hospitals, and patient visits within clinics. Hospital staff were asked to complete Patient Record forms for a systematic random sample of patient visits occurring during a randomly assigned 4-week reporting period during the survey year. Sample data are weighted to produce national estimates of patient visits. About 400 emergency departments participated in 1998 and more than 24,000 Patient Record forms were completed. About 230 outpatient departments (OPD) participated in 1998 and about 30,000 Patient Record forms were completed.
Response Rates	The response rates are about 95 percent.
Primary Survey Content	NHAMCS includes two files: ED visits and OPD visits. Information is obtained on various aspects of patient visits, including patient characteristics, physician characteristics, and other visit characteristics. The survey form is redesigned every 2 years to address changing health data needs. Among the items collected are: patient's age, gender, race, and ethnicity; patient's expressed reason for visit; place, cause, work-relatedness, and intentionality of injury, if any; physician's diagnoses; diagnostic services ordered or provided; procedures provided; medications ordered, supplied, administered or continued; providers seen; visit disposition; immediacy with which patient should be seen; time spent with physician; and, expected source of payment.
Population Targeted	The basic sampling unit is the patient visit. Included in the survey are in-person visits by patients to EDs and OPDs of noninstitutional general and short-stay hospitals, exclusive of Federal, military, and Veterans Administration hospitals, located in the 50 States and the District of Columbia. Telephone contacts are excluded.
Demographic Data	Patient's age, gender, race, and ethnicity.
Years Collected	Annual since 1992.
Schedule	Annual.
Geographic Estimates	National, four U.S. Census Bureau regions.

National Hospital Ambulatory Medical Care Survey (NHAMCS)

Notes	The NHAMCS is a visit-based survey rather than a population-based survey. Estimates of visits per person per year can be produced using U.S. Census Bureau civilian noninstitutionalized population estimates. The survey is cross-sectional in nature. Multiple visits may be made by the same person within the sample.
Contact Information	<p>Data system homepage: http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm</p> <p>Data system phone: 301-458-4600</p> <p>Agency homepage: http://www.cdc.gov/nchs</p> <p>Agency phone: 301-458-INFO (4636)</p>
References	McCaig, L.F.; and McLemore, T. Plan and operation of the National Hospital Ambulatory Medical Care Survey. National Center for Health Statistics. <i>Vital and Health Statistics</i> 1(34), 1994.

National Hospital Discharge Survey (NHDS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Manual sample selection and abstraction of inpatient medical records by field personnel or automated data collection through the purchase of electronic files from commercial abstracting sources, States, or hospitals.
Survey Sample Design	The NHDS utilizes a three-stage probability design that includes primary sampling units (PSUs) used for the 1985–94 NHIS, hospitals within PSUs, and discharges within hospitals. The largest hospitals were selected with certainty. The annual number of records included in the survey is approximately 300,000.
Response Rates	The survey response rate averages between 92 and 95 percent annually.
Primary Survey Content	Variables collected include: age; gender; race; ethnicity; admission and discharge dates (length of stay); discharge status; source of payment; hospital size, ownership, and region; from 1-7 diagnoses coded using the ICD-9-CM; and, from 0-4 procedures using the ICD-9-CM.
Population Targeted	Hospital discharges from short-stay noninstitutional hospitals and general and children's general hospitals regardless of length of stay, exclusive of military and U.S. Department of Veteran Affairs hospitals, located within the 50 States and the District of Columbia.
Demographic Data	Patient's age, gender, race, and ethnicity.
Years Collected	1965 to present.
Schedule	Annual.
Geographic Estimates	National, four U.S. Census Bureau regions.
Notes	Data on race are not available for some hospitals because the hospitals provide data from billing forms that do not include race as a required item. A comparison of NHDS data with data for those who reported being hospitalized in the NHIS indicated that under reporting for whites was about 30 percent in 1992; the difference for African Americans was not statistically significant. Hispanic origin is not reported for 75 percent of the NHDS records in 1992. (Kozak, L.J. Under reporting of race in the National Hospital Discharge Survey. Advance Data from Vital and Health Statistics, No. 265. Hyattsville, MD: National Center for Health Statistics, 1995.)

National Hospital Discharge Survey (NHDS)

Contact Information	<p>Data system homepage: http://www.cdc.gov/nchs/about/major/hdasd/nhds.htm</p> <p>Data system phone: 301-458-4321</p> <p>Agency homepage: http://www.cdc.gov/nchs</p> <p>Agency phone: 301-458-INFO (4636)</p>
References	<p>Graves, E.J., and Owings, M.F. 1996 Summary: National Hospital Discharge Survey. <i>Advance data from Vital and Health Statistics</i>. No. 301. Hyattsville, MD: National Center for Health Statistics (NCHS), 1998.</p> <p>Haupt, B.J., and Kozak, L.J. Estimates from two survey designs: National Hospital Discharge Survey. NCHS. <i>Vital and Health Statistics</i> 13 (111), 1992.</p> <p>National Center for Health Statistics. Detailed diagnoses and procedures: National Hospital Discharge Survey. NCHS. <i>Vital and Health Statistics</i> 13, Published annually.</p>

National Household Survey on Drug Abuse (NHSDA)

Sponsor	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA).												
Mode of Administration	Questionnaires are administered in the home by professional survey administrators. Starting in 1999, computer-assisted personal interview (CAPI) and audio computer-administered self interview (ACASI) for sensitive questions are used. Prior surveys used paper and pencil. Self-respondents only; no respondent identifiers are collected.												
Survey Sample Design	Multistage national probability sample with oversampling of youth. In 1997, the survey was administered to 24,505 persons aged 12 years and older, including 7,844 persons aged 12 to 17 years. Oversample of young people (aged 12 to 34 years), African Americans, and Hispanics in 1985–98 surveys. Oversample in California and Arizona in 1997 and 1998. In 1999, the sample size increased to 70,000 people, including 3,600 to 4,600 for the eight most populous States, and 900 to 1,000 for the other States. It included 25,000 youth aged 12 to 17 years, 22,500 young adults aged 18 to 25, and 22,500 adults aged 26 years and older.												
Response Rates	<table><tr><td><u>For 1997:</u></td><td><u>Total</u></td><td><u>12 to 17 years</u></td></tr><tr><td>Household response rate</td><td>93%</td><td>93%</td></tr><tr><td>Individual response rate</td><td>78%</td><td>83%</td></tr><tr><td>Overall response rate</td><td>73%</td><td>77%</td></tr></table> <p>Response rates are slightly higher among the Hispanic and African American populations.</p>	<u>For 1997:</u>	<u>Total</u>	<u>12 to 17 years</u>	Household response rate	93%	93%	Individual response rate	78%	83%	Overall response rate	73%	77%
<u>For 1997:</u>	<u>Total</u>	<u>12 to 17 years</u>											
Household response rate	93%	93%											
Individual response rate	78%	83%											
Overall response rate	73%	77%											
Primary Survey Content	In 1999, the survey contained initiation, recency, and frequency of use of alcohol, tobacco (including smokeless, cigarettes, and cigars), marijuana and other illicit drugs; prescription drug misuse; treatment and prevention-related items.												
Population Targeted	Civilian noninstitutionalized population residing in the United States ages 12 and older.												
Demographic Data	Gender, age, race/ethnicity, education, marital status, employment, income.												
Years Collected	1971 to present. Continuous since 1992.												
Schedule	Annual.												

National Household Survey on Drug Abuse (NHSDA)

Geographic Estimates	<p>National, regional.</p> <p>Beginning in 1999, direct State estimates are possible for California, Texas, Michigan, Pennsylvania, New York, Florida, Illinois, and Ohio, and model-based estimates are possible for other States.</p>
Notes	<p>The sample size, the mode of administration and the survey content changed in 1999.</p>
Contact Information	<p>Data system homepage: http://www.samhsa.gov/OAS/nhsda/nhsda97/httoc.htm</p> <p>Data system phone: Not available</p> <p>Agency homepage: http://www.samhsa.gov</p> <p>Agency phone: 800-729-6686</p>
References	<p>Harrell, A.V. The validity of self-reported drug use data: The accuracy of responses on confidential self-administered answer sheets, In: Harrison, L., and Hughes, A., eds. <i>The Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates</i>. NIDA Research Monograph 167, NIH Pub. No. 96-4147, Washington, DC: Superintendent of Documents, U.S. Government Printing Office (GPO), 1997.</p> <p>Harrison, L., and Hughes, A., eds. <i>The Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates</i>. NIDA Research Monograph 167, NIH Pub. No. 96-4147, Washington, DC: Superintendent of Documents, GPO, 1997.</p> <p>Substance Abuse and Mental Health Services Administration. <i>Development and Implementation of a New Data Collection Instrument for the 1994 National Household Survey on Drug Abuse</i>. HHS Pub. No. (SMA)96-3084, Washington, DC: Superintendent of Documents, GPO, 1996.</p> <p>Gfroerer, J. <i>An Overview of the National Household Survey on Drug Abuse and Related Methodological Research</i>. Proceedings of the Survey Research Section of the American Statistical Association, Joint Statistical Meetings, Boston, MA, August 1992.</p> <p>American Statistical Association. Turner, C.F.; Lessler, J.T.; and Gfroerer, J.C. <i>Survey Measurement of Drug Use: Methodological Studies</i>. National Institute on Drug Abuse. DHHS Pub. No. (ADM) 92-1929, 1992.</p> <p>Needle, R.H.; Jou, S.C.; and Su, S.S. The impact of changing methods of data collection on the reliability of self-reported drug use of adolescents. <i>American Journal of Drug and Alcohol Abuse</i> 15(3):275-289, 1989.</p>

National Notifiable Disease Surveillance System (NNDSS) and National Electronic Telecommunications System for Surveillance (NETSS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Epidemiology Program Office (EPO).
Mode of Administration	Reports are submitted by health care providers and clinical laboratories to the local, county, or State health departments. Weekly transmission of all data reported to CDC is overseen and administered by the State health department.
Survey Sample Design	States determine the diseases that are nationally notifiable, the data that are collected, and method of reporting.
Response Rates	Varies by disease and State. Severe clinical illnesses are more likely to be reported. Persons with clinically mild diseases—usually not associated with severe consequences—may not be seen in health care settings or may not be reported by health care providers. Underreporting is a major limitation of this system.
Primary Survey Content	The Council of State and Territorial Epidemiologists and CDC develop the list of diseases and conditions that are considered nationally notifiable (52 in 1999). However, each State determines which diseases and conditions from the list will be reported from that State; many States also include other diseases and conditions in addition to those on the list of nationally notifiable diseases and conditions. States generally report the internationally quarantineable diseases, in compliance with the World Health Organization regulations. Data include demographic characteristics and other epidemiologically important information.
Population Targeted	Entire population of all States, District of Columbia, and five U.S. territories.
Demographic Data	Race, ethnicity, age, gender.
Years Collected	By 1928, all States, the District of Columbia, Hawaii, and Puerto Rico were participating in public health reporting for nearly 30 specified conditions. In 1984, a system was developed for the electronic transfer of individual case record data, and by 1990, each of the 50 States had begun participating in the system, which was then renamed NETSS. NETSS provides both individual and summary records.
Schedule	Data are transmitted to CDC from the States each week. National data are published annually.
Geographic Estimates	National, regional, State, county.

National Notifiable Disease Surveillance System (NNDSS) and National Electronic Telecommunications System for Surveillance (NETSS)

Notes	Although State health department staff and their CDC colleagues attempt to obtain complete demographic and epidemiologic information, some data (particularly race and ethnicity) are not available for some cases of disease. Laws, regulations, and mandates for public health reporting (including specific data items that are reported) are under the authority of individual States, and in some States, race and ethnicity may not be approved for reporting to the national level. Race and ethnicity data may also be unknown when cases are reported from a laboratory or when cases are reported as aggregate disease totals.
Contact Information	Data system homepage: http://www.cdc.gov/epo/dphs/netss.htm Data system phone: 404-639-0080 Agency homepage: http://www.cdc.gov/epo Agency phone: 404-639-3636

National Profile of Local Health Departments (NPLHD)

Sponsor	Conducted by the National Association of County and City Health Officials, funded through a U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), cooperative agreement.
Mode of Administration	Self-administered questionnaires.
Survey Sample Design	Census of U.S. local health departments.
Response Rates	The response rate for the 1996–97 NPLHD was 88 percent (2,492 of 2,834 local health departments).
Primary Survey Content	Descriptive data on local health departments nationwide, including jurisdiction type, services provided, staff size, community partnerships and collaborative relationships, managed care, and expenditures.
Population Targeted	Local health departments in the United States.
Demographic Data	Jurisdiction type, population size.
Years Collected	1989; 1992–93; 1996–97.
Schedule	Periodic.
Geographic Estimates	National, 10 HHS Regions, State, and county. Data will be geo-coded.
Notes	The NPLHD is a cross-sectional survey, not a longitudinal survey. Questions change from survey to survey.
Contact Information	Data system homepage: http://www.naccho.org Data system phone: 202-783-5550 Agency homepage: http://www.cdc.gov/phppo Agency phone: 770-488-2460
References	National Association of County and City Health Officials. <i>1992–1993 National Profile of Local Health Departments: National Surveillance Series</i> . Atlanta, GA: Centers for Disease Control and Prevention, 1995.

National Survey of Family Growth (NSFG)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Computer-assisted personal interview (CAPI) by professional female interviewers. In addition, a self-administered audio section for more sensitive topics (ACASI), in which respondents hear questions on headphones (and read on a computer screen) and enter responses on the computer themselves.
Survey Sample Design	The 1995 survey was a multistage probability design consisting of households that had been interviewed in 198 PSUs in the National Health Interview Survey in 1993. Of the 13,795 eligible females in the sample, 10,847 were interviewed. Black and Hispanic females were oversampled.
Response Rates	Response rates have averaged around 80 percent for prior cycles; in the most recent cycle, 1995, the response rate was 79 percent.
Primary Survey Content	The NSFG contains data on factors affecting birth and pregnancy rates, adoption, and maternal and infant health. These factors include sexual activity, marriage, divorce and remarriage, unmarried cohabitation, contraception and sterilization, infertility, breastfeeding, pregnancy loss, low birthweight, and use of medical care for family planning and infertility.
Population Targeted	Civilian noninstitutionalized females aged 15 to 44 years residing in the United States.
Demographic Data	Age, race, Hispanic ethnicity, family income, educational attainment.
Years Collected	1973; 1976; 1982; 1988; and 1995. Future surveys will be conducted in 2001, 2004, and 2007.
Schedule	Periodic.
Geographic Estimates	National; four U.S. Census Bureau regions; metropolitan and nonmetropolitan areas; some of the 10 HHS regions.
Notes	The sample size of future surveys will increase. Beginning in 2001, males will be sampled as well as females. Persons aged 15 to 19 and 20 to 24 years will be oversampled as well as black and Hispanic population groups.
Contact Information	Data system homepage: http://www.cdc.gov/nchs/nsfg.htm Data system phone: 301-458-4222 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-INFO (4636)

National Survey of Family Growth (NSFG)

References	<p>Potter, F.J.; Iannacchione, V.G.; Mosher, W.D.; et al. Sampling weights, imputation, and variance estimation in the 1995 National Survey of Family Growth. National Center for Health Statistics (NCHS). <i>Vital and Health Statistics</i> 2(124), 1998.</p> <p>Kelly, J.E.; Mosher, W.D.; Duffer, A.P.; et al. Plan and operation of the 1995 National Survey of Family Growth. NCHS. <i>Vital and Health Statistics</i> 1(36), 1997.</p> <p>Waksberg, J.; Sperry, S.; Judkins, D.; et al. National Survey of Family Growth, Cycle IV, evaluation of linked design. NCHS. <i>Vital and Health Statistics</i> 2(117), 1993.</p> <p>Judkins, D.R.; Mosher, W.D., and Botman, S. National Survey of Family Growth: Design, estimation, and inference. NCHS. <i>Vital and Health Statistics</i> 2(109), 1991.</p> <p>Waksberg, J., and Northrup, D.R. Integration of sample design for the National Survey of Family Growth, Cycle IV, with the National Health Interview Survey. NCHS. <i>Vital and Health Statistics</i> 2(96), 1985.</p>
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National Vital Statistics System, Mortality (NVSS-M)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Administrative records (death certificates) completed by physicians, coroners, medical examiners, and funeral directors are filed with State vital statistics offices; selected statistical information is forwarded to NCHS to be merged into a national statistical file. Beginning with 1989, revised standard certificates replaced the 1978 versions; the next scheduled revision is 2003. Demographic information on the death certificate is provided by the funeral director and is based on information supplied by an informant. Medical certification of cause of death is provided by the physician, medical examiner, or coroner.
Survey Sample Design	NVSS mortality files include data for the 50 States, the District of Columbia, and the territories of Puerto Rico, Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Marianas. All deaths occurring in those areas are included (approximately 2.2 to 2.3 million annually). Data for Healthy People 2010 are based only on resident deaths filed in the 50 States and the District of Columbia. Deaths to nonresidents of the United States are not included.
Response Rates	N/A.
Primary Survey Content	Year of death, place of decedent's residence, place death occurred, age at death, day of week and month of death, Hispanic origin, race, marital status (beginning in 1979), place of birth, gender, underlying and multiple causes of death for all States, injury at work (beginning in 1993), hospital and patient status, educational attainment (beginning in 1989) for selected States, and occupation and industry (beginning in 1984) for selected States.
Population Targeted	The U.S. population.

National Vital Statistics System, Mortality (NVSS-M)

Demographic Data	Gender, race, Hispanic origin (beginning in 1984), age at death, place of decedent's residence, educational attainment (beginning in 1989) for selected States, marital status, and industry and occupation for selected States. Race and ethnic origin are separate items on the death certificate. Beginning with 1992 data, California, Hawaii, Illinois, New Jersey, New York, Texas, and Washington reported expanded Asian and Pacific Islander categories of Asian Indian, Korean, Vietnamese, Samoan, and Guamanian. The rest of the States reported a combined Other Asian and Pacific Islander category in addition to the categories of white, black, American Indian, Chinese, Hawaiian, Japanese, and Filipino that all States report. As of 1997, all States report Hispanic origin. The categories reported include Mexican, Puerto Rican, Cuban, Central and South American, and Other Hispanic.
Years Collected	The data system began in 1900 but not all States participated before 1933. Coverage for deaths has been complete since 1933.
Schedule	Annual.
Geographic Estimates	National, regional, State, and county. Beginning with 1989 data, some changes were initiated to increase confidentiality protection. Identifying information including date of death and geographic identifiers for counties of less than 100,000 persons are not available for public use.
Contact Information	Data system homepage: http://www.cdc.gov/nchs/about/major/dvs/mortdata.htm Data system phone: 301-458-4555 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-4666
References	Hoyert, D.L.; Kochanek, K.D.; and Murphy, S.L. Deaths: Final Data for 1997. <i>National Vital Statistics Reports</i> 19(Suppl. 47). Hyattsville, MD: National Center for Health Statistics (NCHS), 1999. NCHS. <i>Technical Appendix. Vital Statistics of the United States, 1992</i> . Vol. II, Mortality, Part A. HHS Pub. No. (PHS) 96-1101. Washington, DC: U.S. Government Printing Office, 1996.

National Vital Statistics System - Natality (NVSS-N)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Hospital and attendants at delivery are responsible for completion of administrative records (birth certificates), which are filed with State vital statistics offices; selected statistical information is forwarded to NCHS to be merged into a national statistical file. Demographic information is provided by the mother. Medical and health information is generally based on hospital and other records. Beginning with 1989, revised standard certificates replaced the 1978 versions. The next scheduled revision is in 2003.
Survey Sample Design	NVSS natality data include data for the 50 States, the District of Columbia, and the territories of Puerto Rico, Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Marianas. All births are included (approximately 3.9 to 4.0 million annually). Data for Healthy People 2010 are based only on resident births filed in the 50 States and the District of Columbia. Births to nonresidents of the United States are not included.
Response Rates	N/A.
Primary Survey Content	Year of birth, place of birth, prenatal care, demographic information and health status of baby, demographic information of mother and father, pregnancy history of mother, medical and health data about the delivery, pregnancy, and mother.
Population Targeted	All registered births in the United States.
Demographic Data	Gender of baby. Race, Hispanic origin, age, educational attainment, marital status of mother, and live-birth order.
Years Collected	The data system began in 1900 but not all States participated before 1933. Before 1972, only a 50 percent sample of birth certificates was received. Beginning 1972 all birth certificates are included from States participating in the Vital Statistics Cooperative Program (VSCP), with other States continuing to provide data from a 50 percent sample of birth certificates. Beginning 1985, the natality file is based on 100 percent of birth certificates in all States and the District of Columbia.
Schedule	Annual.
Geographic Estimates	National, regional, State, county, and city. Detailed data for counties and cities of 100,000 or more population.

National Vital Statistics System - Natality (NVSS-N)

Contact Information	Data system homepage: http://www.cdc.gov/nchs/births.htm Data system phone: 301-458-4111 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-INFO (4636)
References	Ventura, S.J.; Martin, J.A.; Curtin, S.A.; et al. Births: Final Data for 1998. <i>National Vital Statistics Reports</i> 3(Suppl. 48). Hyattsville, MD: National Center for Health Statistics (NCHS), 2000. NCHS. <i>Technical Appendix. Vital Statistics of the United States, 1992</i> . Vol. I, Natality. HHS Pub. No. (PHS) 96-1100. Washington, DC: U.S. Government Printing Office, 1996.

1999 National Worksite Health Promotion Survey (NWHPS)

Sponsor	Association for Worksite Health Promotion (AWHP), the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (ODPHP), and William M. Mercer, Incorporated.
Mode of Administration	Computer-assisted telephone interview (CATI).
Survey Sample Design	Worksites were defined as an organizational entity comprising 50 or more employees working at a particular geographic location. The sample was drawn randomly from the Dun & Bradstreet universe of employers and classified according to the number of employees at each worksite and Standard Industrial Classification (SIC) code. Size strata were 50-99, 100-249, 250-749, and 750 and more employees. Public sector employers were excluded. Results of the survey were weighted based on the size of the worksite. A total of 1,544 worksites were surveyed in 1998-99.
Response Rates	Overall response rate was 60 percent.
Primary Survey Content	The survey covered employer's health risk and prevention programs and policies provided to their employees; corporate characteristics; corporate perspectives on health, values, support, and barriers; use of health plans for current and future health promotion delivery; delivery mechanisms, cost sharing and incentives; and disease- and demand-management programs and trends.
Population Targeted	Worksites with 50 or more employees, excluding public sector worksites.
Demographic Data	Not applicable.
Years Collected	November 1998-August 1999.
Schedule	Periodic.
Geographic Estimates	National (excluding Alaska and Hawaii).
Notes	There are plans to repeat this survey at least twice between 2001 and 2007 to obtain updates for the Healthy People 2010 objectives that target worksite health promotion programs.
Contact Information	Data system homepage: http://www.awhp.org Data system phone: 847-480-9574 (NWHP) 612-897-8800 (Mercer, Incorporated) Agency homepage: http://odphp.osophs.dhhs.gov Agency phone: 202-205-8611 (ODPHP)
References	Association for Worksite Health Promotion. <i>1999 National Worksite Health Promotion Survey</i> . Northbrook, IL: the Association, 1999.

School Health Policies and Programs Study (SHPPS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).
Mode of Administration	State and district level: Self-administered, mailed questionnaire. School and classroom level: On-site, structured personal interview.
Survey Sample Design	For the 1994 SHPPS, all 50 States and the District of Columbia education agencies; a national probability sample of public and private districts; a national sample of public and private middle/junior and senior high school schools, and a random sample of required health education and physical education classes. About 400 districts and 600 schools participated. Respondents included administrators, teachers, school nurses, counselors, food service staff, secretaries, and other school personnel.
Response Rates	For the 1994 SHPPS: State education agencies, 100 percent; school districts, 82 percent; schools, 79 percent; health education teachers, 63 percent; and physical education teachers, 70 percent.
Primary Survey Content	Characteristics (such as policies, administration, planning, program content, program requirements, teaching methodologies, professional preparation of staff, efforts to promote programs, accessibility of services, training needs, etc.) of school health programs, including health education, physical education, food service, health services, and school health policies were measured in 1994.
Population Targeted	Education agencies in all 50 States and the District of Columbia; public and private school districts; public and private middle/junior and senior high schools; required health education and physical education courses.
Demographic Data	For schools, demographic variables include school size, school type, and urbanicity.
Years Collected	1994; 2000.
Schedule	Periodic: Every 6 years.
Geographic Estimates	National estimates for school districts, schools, and health education and physical education courses; State estimates for State education agencies.

School Health Policies and Programs Study (SHPPS)

Notes	SHPPS is the most comprehensive source of national data on policies and programs that support school health programs. SHPPS 2000 is an expanded version of the 1994 SHPPS. About 800 districts and 1,400 schools were asked to participate, including elementary schools. In addition to the 1994 survey content, SHPPS 2000 assesses mental health and social services, faculty and staff health promotion, and family and community involvement. Demographic data will be expanded to include percent of students receiving free or reduced-price school lunches, student-teacher ratios, and race/ethnic distribution of students.
Contact Information	Data system homepage: http://www.cdc.gov/nccdphp/dash/shpps/index.htm Data system phone: 800-231-6405 Agency homepage: http://www.cdc.gov/nccdphp Agency phone: 770-488-5401
References	Errecart, M.T.; Ross, J.G.; Robb, W.; et al. The School Health Policies and Programs Study (SHPPS): Methodology. <i>Journal of School Health</i> 8(65), 1995.

State Tobacco Activities Tracking and Evaluation System (STATE)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Office on Smoking and Health (OSH).
Mode of Administration	The STATE System is a data warehouse. Data are collected and summarized from various sources, including the Behavioral Risk Factor Surveillance System; the Youth Risk Behavior Surveillance System; the Census Bureau, the Economic Research Service, USDA; and SAMHSA. Specifically for Healthy People 2010 objectives, the Lexis-Nexis on-line legal database is used.
Survey Sample Design	Not applicable. Specifically for Healthy People 2010 objectives, CDC, OSH searches two Lexis-Nexis subfiles: the StateTrack System and the Advanced Legislative Services System. Downloads to the STATE database are coded according to variables identified by CDC, OSH.
Response Rates	N/A.
Primary Survey Content	The system contains data on cigarette and other tobacco use, resident population estimates (number of adults and adolescents), the tobacco industry (tobacco agriculture, manufacturing, and cigarette sales), health consequences and cost, State tobacco-control legislation (smokefree indoor air, youth access, preemption, excise tax on tobacco products, licensure, and advertising), and program implementation (cigarette sales to underage persons).
Population Targeted	State tobacco activities.
Demographic Data	Resident population data grouped by adult and youth.
Years Collected	Continuously since 1996. Released on the Internet in May, 1999.
Schedule	Annually for most data sources, quarterly for State tobacco control legislation.
Geographic Estimates	State (see NOTES).

State Tobacco Activities Tracking and Evaluation System (STATE)

Notes	<p>The STATE System is an electronic data warehouse containing up-to-date and historic State-level data on tobacco use prevention and control. It is designed to integrate many data sources to provide comprehensive summary data and facilitate research and consistent interpretation of the data. The STATE System was developed by CDC, NCCDPHP, OSH.</p> <p>National estimates specifically for Healthy People 2010 are derived by summing the State numbers (for example, number of smokefree indoor air policies) across States.</p>
Contact Information	<p>Data system homepage: http://www2.cdc.gov/nccdphp/osh/state/</p> <p>Data system phone: 770-488-5703</p> <p>Agency homepage: http://www.cdc.gov/tobacco</p> <p>Agency phone: 770-488-5701</p>
References	<p>Centers for Disease Control and Prevention (CDC). Tobacco use among middle and high school students, United States, 1999. <i>Morbidity and Mortality Weekly Report</i> 49(03): 49-53, 2000.</p> <p>CDC. Surveillance for selected tobacco use behaviors, United States, 1900–94. <i>Morbidity and Mortality Weekly Report</i> 43(SS-3):49-53, 1994.</p> <p>CDC. Attitudes toward smoking policies in eight States, United States, 1993. <i>Morbidity and Mortality Weekly Report</i> 43(43): 786-789, 1994.</p>

STD Surveillance System (STDSS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for HIV, STD, and TB Prevention (NCHSTP).
Mode of Administration	Reports from health care providers are sent to the local/State/territorial health departments.
Survey Sample Design	All 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and 64 select large cities report STD cases.
Response Rates	Response rates vary by disease and patient population. Estimates of completeness for case reporting of syphilis, gonorrhea, and chlamydia are 65, 50, and 20 percent, respectively.
Primary Survey Content	Summary case count data are submitted monthly, quarterly, and annually using OMB-approved hard copy forms. Hard copy reporting is being replaced by electronic line-listed data. Currently, electronic line-listed data are submitted by more than half of the reporting States. Disease-specific information and demographics are available.
Population Targeted	Health care providers and laboratories providing medical care and laboratory services to persons with STDs.
Demographic Data	Age, gender, race, ethnicity, State and county of residence, country of birth.
Years Collected	CDC first provided reports of persons with STDs in 1941.
Schedule	Annual. STD Surveillance Report is published annually and is supplemented by the Chlamydia Prevalence Monitoring Annual Report, the Gonococcal Isolate Surveillance Project (GISP) Annual Report, and the Syphilis Surveillance Report. Report is available on the Web at http://www.cdc.gov/wonder/STD/Contents.shtml .
Geographic Estimates	National, State, regional, and selected large cities and counties. Data release policies dictate that no data that could be used to identify a person reported to the system may be released; thus, release of data in cell sizes less than or equal to five in a given category is prohibited.

STD Surveillance System (STDSS)

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References	<p>Centers for Disease Control and Prevention (CDC), Division of Sexually Transmitted Disease Prevention. <i>Sexually Transmitted Disease Prevention Surveillance</i>. Atlanta, GA: CDC, 1999.</p> <p>CDC. Case definition for infectious conditions under public health surveillance. <i>Morbidity and Mortality Weekly Report</i> 46(RR10), 1997.</p> <p>CDC. Guidelines for evaluating surveillance systems. <i>Morbidity and Mortality Weekly Report</i> 37(S5), 1988.</p>

United States Renal Data System (USRDS)

Sponsor	U.S. Department of Health and Human Services, National Institutes for Health (NIH), National Institute for Diabetes and Digestive and Kidney Disease (NIDDK) in collaboration with the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA).
Mode of Administration	Continuous mandated reporting from physicians who treat end-stage renal disease (ESRD).
Survey Sample Design	The database consists of patient and facility records from the HCFA ESRD Program Management and Medical Information System, the Annual Facility Survey, and data on transplant followup and Medicare parts A and B services derived from Medicare claims. These HCFA-supplied data are supplemented by data from the Social Security Administration, the U.S. Department of Veterans Affairs facilities, the U.S. Census Bureau, local and national ESRD provider databases, and international ESRD registries. Patient-specific data are compiled from medical records, as well as data on medical providers and treatment facilities. Special studies utilize random samples of patient population medical records.
Response Rates	About 96 percent of all treated ESRD patients in the United States are covered.
Primary Survey Content	Date of onset of ESRD, treatment modality (including dialysis and kidney transplantation), causes of death, patient survival, hospitalization, cost and cost effectiveness, and institutional providers of ESRD treatment. Questions in special surveys cover behavioral risk factors (for example, alcohol and tobacco use), preventive health measures, health status, limitation of activity, and health care access and utilization.
Population Targeted	Medicare and non-Medicare ESRD patients. The USRDS contains data on approximately 1 million patients treated between 1977 and 1998.
Demographic Data	Gender, age, income, education, race, Hispanic ethnicity (available since April 1995).
Years Collected	Continuously since 1988.
Schedule	Annual.
Geographic Estimates	National, State, and county.

United States Renal Data System (USRDS)

Notes	The USRDS provides data on the incidence, prevalence, mortality rates, and trends over time of end-stage renal disease by primary diagnosis, treatment modality, and sociodemographic variables. Data are published in an Annual Data Report, which is available on the Internet at http://www.med.umich.edu/usrds . Other data collected by the database include services resources; services utilization; and services expenditures and financing.
Contact Information	Data system homepage: http://www.usrds.org Survey description: http://www.os.dhhs.gov/progorg/aspe/minority/minnih9.htm Agency homepage: http://www.niddk.nih.gov Agency phone: 301-594-1932
References	U.S. Renal Data System (USRDS). <i>1999 Annual Data Report</i> . Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. Published annually.

Youth Risk Behavior Surveillance System (YRBSS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).						
Mode of Administration	School based; administered in classrooms by professional survey administrators. Anonymous self-administered questionnaires. Make-up surveys conducted for absentees.						
Survey Sample Design	The YRBSS has several components all of which are administered among samples of 9th through 12th grade students: a national survey, State surveys administered by the States, local surveys administered by 16 of the largest cities, a survey of the Navaho Indian Nation schools, and a census of Bureau of Indian Affairs schools. The national survey uses a three-stage probability sample. It is completed biennially by students in about 150 public and private schools, grades 9-12. African-American and Hispanic/Latino students are over-sampled in the national survey. In the 1999 national survey, N= 15,349; grade 9 = 28.9 percent; grade 10 = 26.0 percent; grade 11 = 23.6 percent; and grade 12 = 21.4 percent.						
Response Rates	<p><u>For 1999:</u></p> <table> <tr> <td>School response rate</td><td>77%</td></tr> <tr> <td>Individual response rate</td><td>86%</td></tr> <tr> <td>Overall response rate</td><td>66%</td></tr> </table>	School response rate	77%	Individual response rate	86%	Overall response rate	66%
School response rate	77%						
Individual response rate	86%						
Overall response rate	66%						
Primary Survey Content	Six categories of health risk behaviors: injury, tobacco use, alcohol and other drug use, sexual behavior, diet and nutrition, and physical activity.						
Population Targeted	Students in grades 9-12.						
Demographic Data	<p>Gender, age, grade, race/ethnicity, urbanicity of school.</p> <p>Race/ethnicity data are collected using a single question. Categories are White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, Hispanic or Latino. Respondents can choose one or more categories. Persons who select "Hispanic or Latino" are only counted as Hispanic or Latino, whereas people who select multiple race categories (not including Hispanic or Latino) are classified as "multiracial." (The number in the multiracial category is very small.) When the data are compiled, persons who select White only are classified as nonHispanic White. Person who select Black or African American only are classified as non-Hispanic Black or African American.</p>						

Youth Risk Behavior Surveillance System (YRBSS)

Years Collected	1990; biennially since 1991.
Schedule	Biennial (odd-numbered years).
Geographic Estimates	National survey: national and four U.S. Census Bureau regions; State survey: 41 States and the District of Columbia in 1999; Local survey: 16 selected large urban school districts in 1999.
Notes	This is one of the few school-based surveys that conducts a makeup survey for students who are absent during the original survey yielding excellent coverage of the in-school youth population. Other components of the YRBSS include a national alternative school survey, middle school surveys in selected States, and the National College Health Risk Behavior Survey. For the 1999 YRBSS, questionnaire revisions were made to be responsive to the Healthy People 2010 objectives and current trends.
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References	<p>Kann, L.; Kichen, S.A.; Williams, B.I.; et al. Youth risk behavior surveillance, United States. <i>Morbidity and Mortality Weekly Report Surveillance Summary</i> 47(SS-3):1-89, 1997.</p> <p>Kann, L.; Warren, C.W.; Harris, W.A.; et al. Youth risk behavior surveillance, United States. <i>Morbidity and Mortality Weekly Report Surveillance Summary</i> 45(SS-4):1-83, 1995.</p> <p>Kann, L.; Kolbe, L.J.; and Collins, J.L. (eds). Measuring the health behavior of adolescents: The Youth Risk Behavior Surveillance System and recent reports on high-risk adolescents. <i>Public Health Reports</i> 108 (Suppl. 1), 1993.</p>

Appendices

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Appendix B. List of Abbreviations and Acronyms Used in *Healthy People 2010*

AADR	age-adjusted death rate
AAMC	Association of American Medical Colleges
ABCs	Active Bacterial Core Surveillance
ABLES	Adult Blood Lead Epidemiology and Surveillance
ACASI	Audio computer administered self interview
ACF	Administration on Children and Families
ACIP	Advisory Committee on Immunization Practices
ACYF	Administration on Children, Youth and Families
ADLs	activities of daily living
ADR	Annual Data Report of USRDS
ADR	adverse drug reaction
AEDS	Alcohol Epidemiologic Data System
AF	Atrial fibrillation
AFDC	Aid to Families with Dependent Children
AGI	Alan Guttmacher Institute
AHCPR	(See AHRQ)
AHRQ	Agency for Healthcare Research and Quality, formerly Agency for Health Care Policy and Research (AHCPR)
AIDS	acquired immunodeficiency syndrome
AIRS	Aerometric Information Retrieval System
ALR	administrative license revocation
APEX/PH	Assessment Protocol for Excellence in Public Health
APNCU	Adequacy of Prenatal Care Utilization Index
ARS	Agricultural Research Service
ASD	Adult Spectrum of Disease Project
ASHP	American Society for Health-Systems Pharmacists
ASOII	Annual Survey of Occupational Injuries and Illnesses
ASPH	Association of Schools of Public Health
ASTDD	Association of State and Territorial Dental Directors
ASTDHPHE	Association of State and Territorial Directors of Health Promotion and Public Health Education
ASTHO	Association of State and Territorial Health Officials
ATPM	Association of Teachers of Preventive Medicine
AWHP	Association for Worksite Health Promotion
BAC	blood alcohol concentration
BDMP	Birth Defects Monitoring Program
BHPr	Bureau of Health Professions
BJS	Bureau of Justice Statistics
BLL	blood lead level
BLS	Bureau of Labor Statistics
BMD	bone mineral density

BMI	body mass index
BOC	U.S. Bureau of the Census
BPHC	Bureau of Primary Health Care
BRFSS	Behavioral Risk Factor Surveillance System
CAP	Computer Assisted Personal Interview
CATI	Computer Assisted Telephone Interview
CDC	Centers for Disease Control and Prevention
CERCLIS	Comprehensive Environmental Response and Cleanup Liability Information System
CFOI	Census of Fatal Occupational Injuries
CFSAN	Center for Food Safety and Applied Nutrition
CIDI	Composite International Diagnostic Interview
CMHS	Center for Mental Health Services
COPD	chronic obstructive pulmonary disease
CPS	Current Population Survey
CPSC	Consumer Product Safety Commission
CSAP	Center for Substance Abuse Prevention
CSFII	Continuing Survey of Food Intakes by Individuals
CSHCN	children with special health care needs
CSTE	Council of State and Territorial Epidemiologists
CTS	Counseling and Testing System (for HIV)
D&C	dilation and curettage
DANS	data analysis system
DAWN	Drug Abuse Warning Network
DBP	diagnostic blood pressure
DHHS	U.S. Department of Health and Human Services
DHPS	Division of Health Promotion Statistics
DIS	Diagnostic Interview Schedule
DMMS	Dialysis Mortality and Morbidity Study
DNA	data not analyzed
DNC	data not collected
DOC	U.S. Department of Commerce
DOI	U.S. Department of the Interior
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
DOT	U.S. Department of Transportation
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSU	data statistically unreliable
DTaP	diphtheria-tetanus-acellular pertussis
DTP	diphtheria-tetanus-pertussis
ECA	Environmental Catchment Area
ED	emergency department
EHDI	Early Hearing Detection and Intervention Program Network
EMS	emergency medical services
EMT	emergency medical technician

EPA	Environmental Protection Agency
EPO	Epidemiology Program Office
EPSDT	Early Periodic Screening, Diagnosis, and Treatment Program
ESRD	end-stage renal disease
FARS	Fatality Analysis Reporting System
FAS	Fetal Alcohol Syndrome
FASNet	Fetal Alcohol Syndrome Network
FBDO	foodborne disease outbreak
FDA	Food and Drug Administration
FHWA	Federal Highway Administration
FOBT	fecal occult blood test
FSIS	Food Safety and Inspection Service
FSS	Food Safety Survey
FWS	Fish and Wildlife Service
GED	General Education Development
GES	General Estimates System
HbA _{1c}	glycosylated hemoglobin
HBV	hepatitis B virus
HCFA	Health Care Financing Administration
HCUP	Health Care Cost and Utilization Project
HCV	hepatitis C virus
HDL	high-density lipoprotein
Hib	Hæmophilus influenzae type B
HIV	human immunodeficiency virus
HMO	health maintenance organization
HPV	human papillomavirus
HRSA	Health Resources and Services Administration
HSI	health status indicators
ICA	International Communication Association
ICD-#	International Classification of Diseases
ICD-#-CM	International Classification of Diseases – Clinical Modification
ICU	intensive care unit
IHS	Indian Health Service
IRIS	Integrated Risk Information System
IUD	intrauterine device
JCAHO	Joint Commission for the Accreditation of Healthcare Organizations
LBW	low birth weight
LDL	low-density lipoprotein
LHI	Leading Health Indicator
LMP	last normal menstrual period
LUST	leaking underground storage tank
MADDSP	Metropolitan Atlanta Developmental Disabilities Surveillance Program
MAUDE	Manufacturer and User Device Experience Database

MCHB	Maternal and Child Health Bureau
MCL	maximum contaminant level
MCO	managed care organization
MEPS	Medical Expenditure Panel Survey
MHSIP	Mental Health Statistics Improvement Program
MMR	measles, mumps, and rubella vaccine
MSA	metropolitan statistical area
MTF	Monitoring the Future Study
NA	not applicable
NAAQS	National Ambient Air Quality Standards
NACCHO	National Association of County and City Health Officials
NAMCS	National Ambulatory Medical Care Survey
NBDPN	National Birth Defects Prevention Network
NCA	National Communication Association
NCANDS	National Child Abuse and Neglect Data System
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCHRBS	National College Health Risk Behavior Survey
NCHS	National Center for Health Statistics
NCHSTP	National Center for HIV, STD, and TB Prevention
NCI	National Cancer Institute
NCID	National Center for Infectious Diseases
NCQA	National Committee on Quality Assurance
NCS	National Comorbidity Survey
NCSD	National Coalition of STD Directors
NCSL	National Conference of State Legislators
NCUTLO	National Committee on Uniform Traffic Law and Ordinances
NCVS	National Crime Victimization Survey
NEISS	National Electronic Injury Surveillance System
NETSS	National Electronic Telecommunications System for Surveillance
NFNS	National Food and Nutrition Survey
NFP	natural family planning
NHAMCS	National Hospital Ambulatory Medical Care Survey
NHANES	National Health and Nutrition Examination Survey
NHDS	National Hospital Discharge Survey
NHIS	National Health Interview Survey
NHSDA	National Household Survey on Drug Abuse
NHTSA	National Highway Traffic Safety Administration
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health

NIMH	National Institute of Mental Health
NIOSH	National Institute for Occupational Safety and Health
NIP	National Immunization Program
NIS	National Immunization Survey
NLAES	National Longitudinal Alcohol Epidemiologic Survey
NNDSS	National Notifiable Disease Surveillance System
NNHS	National Nursing Home Survey
NNIS	National Nosocomial Infections Surveillance System
NOPUS	National Occupant Protection Use Survey
NPCR	National Program of Cancer Registries
NPL	National Priorities List
NPLHD	National Profile of Local Health Departments
NPTS	National Personal Transportation Survey
NRC	Natural Resource Council
NSAM	National Survey of Adolescent Males
NSFG	National Survey of Family Growth
NSSPM	National Surveillance System for Pneumoconiosis Mortality
NTD	neural tube defect
NVSS	National Vital Statistics System
NWHPS	1999 National Worksite Health Promotion Survey
OAEHP	Office of Analysis, Epidemiology, and Health Promotion
OAQ	Office on Air Quality
ODPHP	Office of Disease Prevention and Health Promotion
OMB	Office of Management and Budget
OPA	Office of Population Affairs
OPD	outpatient department
OPDRA	Office of Postmarketing Drug Risk Assessment
OPHS	Office of Public Health and Science
OSH	Office of the Secretary of Health
OSHA	Occupational Safety and Health Administration
OSWER	Office of Solid Waste Enforcement and Remediation
PAR	police accident report
PATCH	Planned Approach to Community Health
PATH	Projects for Assistance in Transition from Homelessness
PCC	Poison Control Center
PE	physical education
PedNSS	Pediatric Nutrition Surveillance System
PHPPO	Public Health Practice Program Office
PID	pelvic inflammatory disease
PNSS	Pregnancy Nutrition Surveillance System
POS	point-of-service
PPO	preferred provider organization
PRMS	Annual Patient Registration Management System
PSU	primary sampling unit
PWSS	Potable Water Surveillance System

RCRA	Resource Conservation and Recovery Act
RCRIS	Resource Conservation and Recovery Act Information System
RSE	relative standard error
SAMHSA	Substance Abuse and Mental Health Services Administration
SBA	spina bifida and anencephaly
SBP	systolic blood pressure
SDWIS	Safe Drinking Water Information System
SEER	Surveillance, Epidemiology, and End Results
SEMARNAP	Secretary for the Environment, Natural Resources, and Fisheries of Mexico
SES	socioeconomic status
SHEPS	School Health Education Profiles
SHPPS	School Health Policies and Programs Study
SIC	standard industrial classification
SIDS	sudden infant death syndrome
SIPP	Survey of Income and Program Participation
SMI	serious mental illness
SPF	sun protective factor
SSI	supplementary security income
STATE	State Tobacco Activities Tracking and Evaluation System
STD	sexually transmitted disease
STDSS	STD Surveillance System
TB	tuberculosis
TEDS	Treatment Episodes Data System
TESS	Toxic Exposure Surveillance System
TRI	Toxics Release Inventory
TSDF	treatment, storage, and disposal facilities
UA	urban area
UFDS	Uniform Facility Data Set
UNOS	United Network for Organ Sharing
USDA	U.S. Department of Agriculture
USGS	U.S. Geological Survey
USRDS	U.S. Renal Data System
UST	underground storage tank
VBAC	vaginal birth after previous cesarian
VAERS	Vaccine Adverse Event Reporting System
VAPP	vaccine-associated paralytic polio
VLBW	very low birth weight
VLDL	Very low density lipoprotein
VSD	Vaccine Safety Datalink
WFRS	Water Fluoridation Reporting System
WHO	World Health Organization
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
YRBSS	Youth Risk Behavior Surveillance System

Appendix C. Baselines for Age-Adjusted Mortality Objectives Using Rates Age Adjusted to 1940 and to 2000 Standards: United States, 1998

Objective number	Short objective text	Total population		Male		Female		White		Black or African American		American Indian or Alaska Native		Asian or Pacific Islander		Hispanic or Latino ¹	
		1940	2000	1940	2000	1940	2000	1940	2000	1940	2000	1940	2000	1940	2000	1940	2000
		1940	2000	1940	2000	1940	2000	1940	2000	1940	2000	1940	2000	1940	2000	1940	2000
3.1	All cancer	123.6	202.4	147.7	252.4	105.5	169.2	121.0	199.3	161.2	255.1	83.4	129.3	74.8	124.2	76.1	123.7
3.2	Lung cancer	37.0	57.6	49.5	79.9	27.0	41.5	36.8	57.5	44.6	66.7	25.1	38.2	17.2	29.3	13.6	22.7
3.3	Female breast cancer	18.8	27.9	...	...	18.8	27.9	18.3	27.3	25.3	35.7	10.3	14.2	9.8	13.1	12.1	16.8
3.4	Cervical cancer	2.3	3.0	...	...	2.3	3.0	2.1	2.7	4.4	6.0	1.7	2.5	2.2	3.3	2.5	3.3
3.5	Colorectal cancer	11.8	21.2	14.3	25.4	9.9	18.2	11.5	20.8	16.5	28.2	8.2	13.3	7.8	13.7	7.4	12.8
3.6	Oropharyngeal cancer	2.0	3.0	3.1	4.5	1.1	1.7	1.8	2.8	3.3	4.5	1.4	2.1	1.5	2.2	1.2	1.8
3.7	Prostate cancer	13.2	32.0	13.2	32.0	...	...	12.0	29.4	30.3	68.7	7.4	15.9	4.7	12.4	9.0	20.9
3.8	Melanoma	1.9	2.8	2.7	4.1	1.2	1.8	2.2	3.1	0.3	0.5	*	*	0.2	0.3	0.5	0.8
5.5	Diabetes-related ²	40.7	75.2	47.2	87.1	35.6	66.7	37.0	69.8	76.3	129.9	66.4	106.5	30.7	61.6	48.3	86.3
12.1	Coronary heart disease	96.8	208.3	131.8	264.9	68.0	165.2	94.1	206.0	133.2	252.0	70.1	126.2	53.6	123.3	68.3	144.7
12.7	Stroke	25.1	59.6	26.6	60.1	23.6	58.3	23.3	57.6	41.4	80.3	19.6	37.7	22.7	50.6	19.0	39.2
13.14	HIV infection	4.6	4.9	7.2	7.7	2.2	2.3	2.6	2.7	20.6	22.1	2.2	2.3	0.8	0.8	6.2	6.7
15.3	Firearm-related injuries	11.3	11.3	19.6	20.1	3.3	3.3	9.5	10.0	22.7	20.3	12.0	11.3	4.4	4.2	10.4	9.7
15.8	Poisoning	6.3	6.8	9.0	9.6	3.8	4.1	6.5	6.9	7.3	7.9	7.9	8.1	1.5	1.6	5.6	5.9
15.9	Suffocation	3.5	4.1	5.2	6.0	1.8	2.4	3.5	4.1	3.5	4.2	7.2	7.6	2.9	3.5	2.8	3.1
15.13	Unintentional injuries	29.3	35.0	42.1	49.4	17.1	22.1	29.1	34.8	34.3	39.5	54.9	59.9	14.0	17.6	27.4	30.2
15.15a	Motor vehicle crashes	15.2	15.6	20.9	21.6	9.6	10.1	15.2	15.6	16.2	16.8	30.3	30.4	8.5	9.3	14.6	14.7
15.25	Fire	1.0	1.2	1.3	1.6	0.8	0.9	0.8	1.0	2.4	3.0	1.8	2.1	0.2	0.3	0.7	0.9
15.27	Falls	2.3	4.7	3.4	6.4	1.4	3.5	2.4	4.9	1.9	3.1	3.1	4.4	1.5	3.4	2.2	3.7
15.29	Drowning	1.6	1.6	2.7	2.7	0.6	0.6	1.5	1.5	2.4	2.3	3.0	3.1	1.5	1.5	1.6	1.5
15.32	Homicide	7.1	6.5	11.0	10.0	3.2	3.1	4.3	4.0	24.8	22.6	9.5	9.1	3.6	3.5	9.7	8.8
18.1	Suicide	10.4	11.3	17.2	19.2	4.0	4.3	11.2	12.2	5.9	5.8	13.4	12.6	5.9	6.6	6.0	6.3
24.10	Chronic obstructive pulmonary deaths (aged 45 years and older)	78.1	119.4	95.4	153.7	66.2	98.8	81.0	124.3	61.3	85.3	57.3	79.6	26.8	48.6	30.4	52.5
26.2	Cirrhosis	7.2	9.5	10.3	13.4	4.4	6.0	7.1	9.4	8.0	9.9	22.0	25.9	2.4	3.5	11.7	15.4
26.3	Drug-induced	5.9	6.3	8.2	8.6	3.6	3.9	5.8	6.1	8.1	8.8	6.7	7.0	1.2	1.2	5.9	6.2

...Not applicable. ²Data are unreliable. Based on fewer than 20 deaths. ¹Hispanic origin can be of any race. ³1997 data using any mention of diabetes on the death certificate.

Appendix D. ICD-9 Codes for Cause-Specific Healthy People 2010 Mortality Objectives

Objective Number	Cause of Death **	ICD-9 Identifying Codes
3-1	Cancer (all sites)	140-208
3-2	Lung cancer	162
3-3	Female breast cancer	174
3-4	Cervical cancer	180
3-5	Colorectal cancer	153-154
3-6	Oropharyngeal cancer	140-149
3-7	Prostate cancer	185
3-8	Malignant melanoma	172
4-2	Cardiovascular mortality in ESRD patients	Underlying cause: 390-448 Contributing cause: 585
5-5 [†]	Diabetes-related deaths	250
5-6 [†]	Diabetes-related deaths among known persons with diabetes	250
5-7 [†]	Cardiovascular deaths among persons with diabetes	Underlying cause: 390-448 Contributing cause: 250
10-4	Food allergies	Developmental
12-1	Coronary heart disease	402, 410-414, 429.2
12-7	Stroke	430-438
13-14	HIV infection	*042-*044
15-3	Firearm-related deaths	E922, E955.0-E955.4, E965.0-E965.4, E970, E985.0- E985.4
15-8	Poisoning	E850-E869, E950-E952, E962, E972, E980-E982
15-9	Suffocation	E911-E913, E953, E963, E983
15-13	Unintentional injuries	E800-E869, E880-E929
15-15	Motor vehicle crashes	E810-E819
15-16	Pedestrian deaths	E810-E819 [†]
15-25	Residential fires	E890-E899
15-27	Falls	E880-E886, E888
15-29	Drownings	E830, E832, E910
15-32	Homicides	E960-E969
16-1f	Birth defects	740-759
16-1g	Congenital heart and vascular defects	745-747
16-1h	Sudden infant death syndrome	798.0
16-4	Maternal deaths	630-676
18-1	Suicide	E950-E959

20-4 [†]	Pneumoconiosis	500-505
24-1	Asthma	493
24-10	Chronic obstructive pulmonary diseases	490-496
26-1	Motor-vehicle crash deaths: a. Alcohol-related c. Drug-related	E810-E819 [‡]
26-2	Cirrhosis	571
26-3	Drug-induced deaths	292, 304, 305.2-305.9, E850-E858, E950.0-E950.5, E962.0, E980.0-E980.5

The “” used in ICD-9 *042-*044 indicates that the codes were added after the classification was adopted.

**Unless otherwise specified, Healthy People 2010 uses underlying cause-of-death data.

[†]Healthy People 2010 uses multiple-cause-of-death data.

[‡]Includes only those deaths assigned to E810-E819 that were associated with alcohol-related or drug-related crashes.

NOTE: See Part B: Operational Definitions for more information.

Appendix E. ICD-9-CM Codes for Cause-Specific Healthy People 2010 Morbidity Objectives

Objective Number	Condition*	ICD-9-CM Identifying Codes
2-10 [†]	Vertebral fractures	805.0, 805.2, 805.4, 805.8
5-10 [†]	Lower extremity amputations in persons with diabetes	84.1 (amputation - procedure code) 250 (diabetes)
12-6	Congestive heart failure	428.0
14-17	Peptic ulcer	531-534
15-1	Nonfatal head injuries	800-801, 803-804, 850-854, 870-873, 925
15-2	Nonfatal spinal cord injuries	806, 952
15-7	Nonfatal poisonings	E850-E869, E950-E952, E962, E972, E980-E982
15-12	Injuries	E800-E869, E880-E929, E950-E999
15-28	Hip fractures	820
15-30	Nonfatal dog bite injuries	E906.0
16-5 [†]	Maternal morbidity	641, 666, 642.4-642.7, 648.8, 664.2, 664.3, 664.5, 665.0-665.1, 665.2-665.9, 658.4, 670, 659.2, 659.3, 646.6, 674.1-674.3, 668, 671.3-671.4, 673, 669.0-669.4, 674.8-674.9, 646.7, 643.2, 671.5, 674.0, 648.0, 642.0-642.3, 642.9, 648.5-648.6, 646.2, 672
16-15	Spina bifida and other NTDs	740-742.0
24-2	Asthma	493
24-3	Asthma	493
28-12	Otitis media	381.0-381.4, 382

*Unless otherwise specified, Healthy People 2010 uses primary (first-listed) diagnosis.

[†]Healthy People 2010 uses any-listed diagnoses.

NOTE: See Part B: Operational Definitions for more information.

Appendix F: Crosswalk From Healthy People 2010 Objectives to Healthy People 2000 Objectives

Healthy People 2010 Objective Number	Healthy People 2000 Objective Number	Healthy People 2000 Duplicate Objectives	Healthy People 2010 Objective Number	Healthy People 2000 Objective Number	Healthy People 2000 Duplicate Objectives
1-1 ^a	21.4		3-1 ^a	16.1	2.2
1-2 ^a	21.4		3-2 ^a	16.2	3.2
1-3a ^a	1.12		3-3 ^a	16.3	
1-3b ^a	2.21		3-4 ^a	16.4	
1-3c ^a	3.16		3-5 ^a	16.5	2.23
1-3d ^a	4.19		3-6 ^a	13.7	3.17, 16.17
1-3e ^a	9.21		3-7		
1-3f ^a	14.12	5.10	3-8		
1-3g ^a	18.9	19.14	3-9a		
1-3h ^a	17.18		3-9b ^a	16.9	
1-4a-b ^a	21.3		3-10a-c ^a	16.10, 3.16	
1-4c	21.3		3-10d-h ^a	16.10	
1-5			3-11a-b ^a	16.12	
1-6			3-12a-b ^a	16.13	
1-7			3-13 ^a	16.11	
1-8a-d	21.8		3-14		
1-8e-h ^a	21.8a		3-15		
1-8i-t ^a	21.8				
1-9a ^a	11.1b		4-1 ^a	15.3	
1-9b			4-2		
1-9c			4-3		
1-10			4-4		
1-11			4-5		
1-12			4-6		
1-13			4-7 ^a	17.10	
1-14a-b			4-8		
1-15					
1-16			5-1 ^a	17.14	
			5-2 ^a	17.11	2.24
2-1			5-3 ^a	17.11	2.24
2-2			5-4		
2-3			5-5 ^a	17.9	
2-4			5-6		
2-5			5-7		
2-6			5-8		
2-7			5-9		
2-8			5-10 ^a	17.10	
2-9			5-11		
2-10			5-12		
2-11			5-13 ^a	17.23	

Appendix F: Crosswalk From Healthy People 2010 Objectives to Healthy People 2000 Objectives (continued)

5-14		8-12a ^a	11.14	
5-15		8-12b-d		
5-16		8-13		
5-17		8-14		
		8-15 ^a	11.8	
6-1		8-16a-c		
6-2		8-17		
6-3		8-18 ^a	11.6	
6-4		8-19 ^a	11.12	
6-5		8-20		
6-6		8-21		
6-7a-b		8-22 ^a	11.11	
6-8		8-23		
6-9		8-24a-d		
6-10		8-25a-p		
6-11		8-26		
6-12		8-27a-j	11.16	
6-13a-b		8-27k-o		
		8-28		
7-1	8.2	8-29		
7-2a-g, ^a	8.4	8-30a-l		
i-j ^a				
7-2h ^a	8.4, 2.19	9-1 ^a	5.2	
7-3	8.5	9-2		
7-4a-d		9-3	5.12	
7-5a-f ^a	8.6	9-4	5.7	
7-6 ^a	8.7	9-5		
7-7 ^a	8.12	9-6		
7-8		9-7	5.1	
7-9 ^a	8.12	9-8a-b ^a	5.4	18.3, 19.9
7-10 ^a	8.10	9-9a-b ^a	5.4	18.3, 19.9
7-11a-b, ^a	8.11	9-10a-d, ^a	5.6	
d-f, ^a j-l, ^a		g-h ^a		
p-q, ^a s, ^a		9-10e ^a	19.10a	18.4a
w-x, ^a z, ^a		9-10f ^a	19.10b	18.4b
bb ^a		9-11a-c ^a	5.8	
7-11c,g-i,	8.11	9-12 ^a	5.3	
m-o, r, t-v,		9-13		
y, aa				
7-12	8.8	10-1a-d	12.1	
		10-1e-g		
8-1a-g ^a	11.5	10-2a ^a	12.2	
8-2a-d		10-2b	12.2	
8-3		10-3a-p		
8-4 ^a	11.7	10-4		
8-5 ^a	11.9	10-5 ^a	12.3	
8-6	11.3	10-6		
8-7		10-7		
8-8 ^a	11.10			
8-9		11-1		
8-10		11-2		
8-11 ^a	11.4			

Appendix F: Crosswalk From Healthy People 2010 Objectives to Healthy People 2000 Objectives (continued)

11-3			14-4 ^a	20.7	
11-4			14-5a-d ^a	20.10	
11-5			14-6 ^a	20.3	
11-6			14-7 ^a	20.7	
			14-8		
12-1 ^a	15.1	1.1, 2.1, 3.1	14-9	20.3	
			14-10		
12-2			14-11	20.4	
12-3			14-12		
12-4			14-13 ^a	20.18	
12-5			14-14		
12-6a-c			14-15 ^a	20.6	
12-7 ^a	15.2	2.22, 3.18	14-16		
12-8			14-17 ^a	17.21	
12-9			14-18 ^a	20.9	
12-10 ^a	15.4	2.26	14-19		
12-11 ^a	15.5		14-20a-e ^a	20.5	
12-12 ^a	15.13		14-21 ^a	20.5	
12-13 ^a	15.6	2.27	14-22a ^a	20.11	
12-14 ^a	15.7	2.25	14-22b-e	20.11	
12-15 ^a	15.14		14-22f		
12-16			14-23a-c, f-h	20.11	
13-1	18.2		14-23d-e,i-j		
13-2	18.2a		14-24a ^a	20.11	
13-3	18.2b		14-24b		
13-4 ^a	18.2		14-25a-b		
13-5 ^a	18.2		14-26		
13-6 ^a	19.10	18.4	14-27a-d ^a	20.11	
13-7 ^a	18.8		14-28a		
13-8 ^a	18.5		14-28b	20.11	
13-9			14-28c	20.11	10.9
13-10			14-29a-f	20.11	
13-11			14-30a-b		
13-12			14-31		
13-13a-f					
13-14			15-1 ^a	9.9	
13-15			15-2 ^a	9.10	
13-16			15-3 ^a	7.3	
13-17			15-4 ^a	7.11	
			15-5		
14-1a,e-f, h-l	20.1		15-6		
14-1b-d, ^a g, ^a j-k ^a	20.1		15-7 ^a	9.8	
			15-8		
14-2	20.3f		15-9		
14-3a-c ^a	20.3		15-10		
14-3d	20.3a		15-11		
14-3e	20.3b	19.7	15-12		
14-3f	20.3c	19.7	15-13 ^a	9.1	
14-3g	20.3e	10.5	15-14 ^a	9.2	
			15-15a ^a	9.3	

Appendix F: Crosswalk From Healthy People 2010 Objectives to Healthy People 2000 Objectives (continued)

15-15b	9.3		16-17a-b, ^a	14.10	
15-16	9.3f		d ^a		
15-17			16-17c	14.10	
15-18			16-18 ^a	14.4	
15-19	9.12		16-19a-b	14.9	2.11
15-20	9.12		16-19c ^a	14.9	2.11
15-21	9.13		16-20a-c ^a	14.15	
15-22	9.26		16-21		
15-23	9.13		16-22		
15-24 ^a	9.24		16-23 ^a	17.20	
15-25 ^a	9.6				
15-26a-b ^a	9.17		17-1a-b		
15-27 ^a	9.4		17-2a-b		
15-28a-b ^a	9.7		17-3 ^a	12.6	
15-29 ^a	9.5		17-4 ^a	12.8	
15-30			17-5a-b ^a	12.8	
15-31 ^a	9.19	13.16	17-6		
15-32 ^a	7.1				
15-33a-b ^a	7.4		18-1 ^a	6.1	7.2
15-34 ^a	7.5		18-2	7.8	6.2
15-35 ^a	7.7		18-3		
15-36			18-4		
15-37 ^a	7.6		18-5		
15-38 ^a	7.9		18-6		
15-39 ^a	7.10		18-7		
			18-8		
16-1a	14.2		18-9a,c-d		
16-1b			18-9b ^a	6.7	
16-1c	14.1		18-10		
16-1d	14.1d		18-11		
16-1e	14.1g		18-12		
16-1f-h			18-13		
16-2a-b			18-14		
16-3a-c					
16-4	14.3		19-1		
16-5a ^a	14.7		19-2 ^a	2.3	1.2, 15.10, 17.12
16-5b-c					
16-6a	14.11		19-3a-c ^a	2.3	1.2, 15.10, 17.12
16-6b					
16-7			19-4	2.4	
16-8 ^a	14.14		19-5 ^a	2.6	16.8
16-9a ^a	14.8a		19-6 ^a	2.6	16.8
16-9b ^a	14.8b		19-7 ^a	2.6	16.8
16-10a-b	14.5		19-8 ^a	2.5	15.9, 16.7
16-11a-c			19-9 ^a	2.5	15.9, 16.7
16-12 ^a	14.6		19-10 ^a	2.9	
16-13			19-11 ^a	2.8	
16-14a-d			19-12a-c ^a	2.10	
16-15 ^a	14.17		19-13 ^a	2.10e	
16-16a-b			19-14		
			19-15 ^a	2.17	

Appendix F: Crosswalk From Healthy People 2010 Objectives to Healthy People 2000 Objectives (continued)

19-16 ^a	2.20	22-1 ^a	1.5	
19-17 ^a	2.21	22-2 ^a	1.3	15.11, 17.13
19-18		22-3 ^a	1.4	
20-1a	10.1	22-4 ^a	1.6	
20-1b	10.1a	22-5 ^a	1.6	
20-1c	10.1b	22-6 ^a	1.3	15.11, 17.13
20-1d	10.1c	22-7 ^a	1.4	
20-1e	10.1d	22-8a-b		
20-2a	10.2	22-9	1.8	
20-2b	10.2a	22-10	1.9	
20-2c	10.2b	22-11		
20-2d	10.2c	22-12		
20-2e	10.2d	22-13 ^a	1.10	
20-2f	10.2e	22-14a-b		
20-2g ^a	10.2	22-15a-b		
20-2h	10.2f			
20-3	10.3	23-1		
20-4	10.17	23-2		
20-5	10.16	23-3		
20-6		23-4		
20-7 ^a	10.8	23-5		
20-8	10.4	23-6		
20-9	6.11	23-7 ^a	22.7	
20-10		23-8		
20-11 ^a	10.7	23-9		
21-1a ^a	13.1	23-10		
21-1b-c	13.1	23-11		
21-2a, ^a d ^a	13.2	23-12a-c		
21-2b-c	13.2	23-13		
21-3	13.3	23-14		
21-4 ^a	13.4	23-15		
21-5a ^a	13.5	23-16		
21-5b ^a	13.6	23-17		
21-6		24-1a-e		
21-7		24-2a-c ^a	11.1	
21-8a	13.8	24-3a-c		
21-8b ^a	13.8	24-4 ^a	17.4	
21-9	13.9	24-5		
21-10 ^a	13.14	24-6 ^a	17.14b	
21-11		24-7a-f		
21-12		24-8		
21-13		24-9		
21-14		24-10 ^a	3.3	
21-15 ^a	13.15	24-11a-b		
21-16		24-12		
21-17		25-1a-c ^a	19.2	
		25-2	19.1	

Appendix F: Crosswalk From Healthy People 2010

Objectives to Healthy People 2000 Objectives (continued)

25-3	19.3		27-2a ^a	3.9, 4.6	13.17, 3.20
25-4 ^a	19.5		27-2b ^a	4.6	3.20
25-5 ^a	19.5		27-2c ^a	3.9	13.17
25-6 ^a	19.6		27-2d		
25-7			27-3 ^a	3.5	
25-8			27-4a	4.5	3.19
25-9	19.4		27-4b ^a	4.5	3.19
25-10			27-5 ^a	3.6	
25-11 ^a	5.5, 5.6	18.15, 19.16	27-6 ^a	3.7	
			27-7		
25-12			27-8a-c ^a	3.24	
25-13			27-9	3.8	11.17
25-14			27-10		
25-15 ^a	19.15		27-11 ^a	3.10	
25-16			27-12 ^a	3.11	10.18
25-17			27-13a-e	3.12	10.19
25-18 ^a	19.13		27-13f ^a	3.12	10.19
25-19 ^a	19.15		27-13g-h		
			27-14a-b ^a	3.13	
26-1a	4.1	9.23	27-15		
26-1b-d			27-16		
26-2 ^a	4.2		27-17a-b ^a	4.9	3.21
26-3 ^a	4.3		27-17c	4.9	3.21
26-4 ^a	4.4		27-18		
26-5			27-19 ^a	10.20	3.25
26-6			27-20		
26-7			27-21a-b ^a	3.23	
26-8					
26-9a-b	4.5	3.19	28-1		
26-9c-d			28-2		
26-10a,c	4.5	3.19	28-3		
26-10b	4.6	3.20	28-4		
26-11a-b	4.7		28-5		
26-11c-d ^a	4.7		28-6		
26-12	4.8		28-7		
26-13a-b			28-8		
26-14a-c ^a	4.11		28-9		
26-15			28-10		
26-16a-f ^a	4.9	3.21	28-11		
26-17a-c	4.10	3.22	28-12		
26-18			28-13		
26-19			28-14		
26-20			28-15		
26-21			28-16		
26-22			28-17		
26-23			28-18		
26-24	4.15				
26-25	4.18				
27-1a ^a	3.4	15.12, 16.6			
27-1b-d					

^a Healthy People 2010 objective is modified from the comparable Healthy People 2000 objective; see Part B: Operational Definitions for a description of changes.

Appendix G Crosswalk From Healthy People 2000 Objectives to Healthy People 2010 Objectives

Healthy People 2000 Objective Number	Healthy People 2000 Duplicate Objectives	Healthy People 2010 Objective Number	Healthy People 2000 Objective Number	Healthy People 2000 Duplicate Objectives	Healthy People 2010 Objective Number
1.1	2.1, 3.1, 15.1	12-1 ^a	2.15		
1.2	2.3, 15.10, 17.12	19-2, ^a 19-3 ^a	2.16		
1.3	15.11, 17.13	22-6 ^a	2.17		19-15 ^a
1.3		22-2 ^a	2.18		
1.4		22-3 ^a	2.19		7-2h ^a
1.4		22-7 ^a	2.20		19-16 ^a
1.5		22-1 ^a	2.21		19-17 ^a
1.6		22-4 ^a	2.21		1-3b ^a
1.6		22-5 ^a	2.22	3.18, 15.2	12-7 ^a
1.7	2.7		2.23	16.5	3-5 ^a
1.8		22-9	2.24	17.11	5-2 ^a
1.8			2.24	17.11	5-3 ^a
1.9		22-10	2.25	15.7	12-14 ^a
1.10		22-13 ^a	2.26	15.4	12-10 ^a
1.11			2.27	15.6	12-13 ^a
1.12		1-3a ^a	3.1	1.1, 2.1, 15.1	12-1 ^a
1.12		3-10h ^a	3.2	16.2	3-2 ^a
1.13	17.3		3.3		24-10 ^a
2.1	1.1, 3.1, 15.1	12-1 ^a	3.4	15.12, 16.6	27-1a ^a
2.2	16.1	3-1 ^a	3.5		27-3 ^a
2.3	1.2, 15.10, 17.12	19-2 ^a	3.6		27-5 ^a
2.3		19-3a-c ^a	3.7		27-6 ^a
2.4		19-4	3.7		27-7
2.5	15.9, 16.7	19-8 ^a	3.8	11.17	27-9
2.5		19-9 ^a	3.9	13.17	27-2c ^a
2.6		19-5 ^a	3.9, 3.20	13.17, 4.6	27-2a ^a
2.6		19-6 ^a	3.10		27-11
2.6	16.8	19-7 ^a	3.11	10.18	27-12 ^a
2.7			3.12	10.19	27-13a-e
2.8		19-11 ^a	3.12	10.19	27-13f ^a
2.9		19-10 ^a	3.13		27-14a-b ^a
2.10		19-12a-c ^a	3.14		
2.10e		19-13 ^a	3.15		
2.11	14.9	16-19a-b	3.16		1-3c ^a
2.11	14.9	16-19c ^a	3.16		3-10a-c ^a
2.12	13.11		3.17	13.7, 16.17	3-6 ^a
2.13			3.18	2.22, 15.2	12-7 ^a
2.14			3.19	4.5	26-9a
			3.19	4.5	26-9b
			3.19	4.5	26-10a,c
			3.19	4.5	27-4a

Appendix G: Crosswalk From Healthy People 2000 Objectives to Healthy People 2010 Objectives (continued)

3.19	4.5	27-4b ^a	5.8		9-11a-c ^a
3.20	4.6	26-10b	5.9		
3.20	4.6	27-2b ^a	5.10	14.12	1-3f ^a
3.21	4.9	26-16a-f ^a	5.11	18.13,	
3.21	4.9	27-17a-b ^a		19.11	
3.21	4.9	27-17c	5.12		9-3
3.22	4.10	26-17a-c			
3.23		27-21a-b ^a	6.1	7.2	18-1 ^a
3.24		27-8a-c ^a	6.2	7.8	18-2
3.25	10.20	27-19 ^a	6.3		
3.26			6.4		
			6.5		
4.1	9.23	26-1a	6.6		
4.2		26-2 ^a	6.7		18-9b ^a
4.3		26-3 ^a	6.8		
4.4		26-4 ^a	6.9		
4.5	3.19	26-9a-b	6.10	7.18	
4.5	3.19	26-10a,c	6.11		20-9
4.5	3.19	27-4a	6.12		
4.6	3.20	26-10b	6.13		
4.6	3.20	27-2b	6.14		
4.7		26-11a-b	6.15		
4.7		26-11c-d ^a			
4.8		26-12	7.1		15-32 ^a
4.9	3.21	26-16a-f ^a	7.2	6.1	18-1 ^a
4.9	3.21	27-17a-b ^a	7.3		15-3 ^a
4.9	3.21	27-17c	7.4		15-33a-b ^a
4.10	3.22	26-17a-c	7.5		15-34 ^a
4.11		26-14a-c ^a	7.6		15-37 ^a
4.12			7.7		15-35 ^a
4.13			7.8	6.2	18-2
4.14			7.9		15-38 ^a
4.15		26-24	7.10		15-39 ^a
4.16			7.11		15-4 ^a
4.17			7.12		
4.18		26-25	7.13		
4.19		1-3d ^a	7.14		
4.20			7.15		
			7.16		
5.1		9-7	7.17		
5.2		9-1 ^a	7.18	6.10	
5.3		9-12 ^a	7.19	9.25	
5.4	18.3, 19.9	9-8a ^a			
5.4	18.3, 19.9	9-8b ^a	8.1	17.1, 21.1	
5.4	18.3, 19.9	9-9a ^a	8.2		7-1
5.4	18.3, 19.9	9-9b ^a	8.3		
5.5, 5.6	18.15,	25-11 ^a	8.4		7-2a-j ^a
	19.16		8.5		7-3
5.6		9-10 a-d,	8.6		7-5a-f ^a
		g-h ^a	8.7		7-6 ^a
5.7		9-4	8.8		7-12

Appendix G Crosswalk From Healthy People 2000 Objectives to Healthy People 2010 Objectives (continued)

8.9			10.2a		20-2b
8.10		7-10 ^a	10.2b		20-2c
8.11		7-11a-b, d- f, j-l, p-q, w-x, z, bb ^a	10.2c 10.2d 10.2e		20-2d 20-2 ^e 20-2f
8.11		7-11c, g-i, m-o, r, t-v, y, aa	10.2f 10.3, 10.13 10.4		20-2h 20-3 20-8
8.12		7-7 ^a	10.5	20.3e	14-3g
8.12		7-9 ^a	10.6		
8.13			10.7		20-11 ^a
8.14			10.8		20-7 ^a
			10.9	20.11	14-28c ^a
9.1		15-13 ^a	10.10		
9.2		15-14 ^a	10.11		
9.3		15-15a ^a	10.12		
9.3		15-15b	10.13		
9.3f		15-16	10.14		
9.4		15-27 ^a	10.15		
9.5		15-29 ^a	10.16		20-5
9.6		15-25 ^a	10.17		20-4
9.7		15-28a-b ^a	10.18	3.11	27-12 ^a
9.8		15-7 ^a	10.19	3.12	27-13b ^a
9.9		15-1 ^a	10.20	3.25	27-19 ^a
9.10		15-2 ^a			
9.11			11.1		24-2a-c ^a
9.12		15-19	11.1b		1.9a
9.12		15-20	11.2	17.8	
9.13		15-21	11.3		8-6
9.13		15-23	11.4		8-11 ^a
9.14			11.5		8-1a-g ^a
9.15			11.6		8-18 ^a
9.16			11.7		8-4 ^a
9.17		15-26a-b ^a	11.8		8-15 ^a
9.18			11.9		8-5 ^a
9.19	13.16	15-31 ^a	11.10		8-8 ^a
9.20			11.11		8-22 ^a
9.21		1-3e ^a	11.12		8-19 ^a
9.22			11.13		
9.23	4.1	26-1a	11.14		8-12a ^a
9.24		15-24	11.15		
9.25	7.19		11.16		8-27a-j
9.26		15-22	11.17	3.8	27-9
10.1		20-1a	12.1		10-1a-d
10.1a		20-1b	12.2		10-2a ^a
10.1b		20-1c	12.2		10-2b
10.1c		20-1d	12.3		10-5 ^a
10.1d		20-1e	12.4		
10.2		20-2a	12.5		
10.2		20-2g ^a	12.6		17-3 ^a

Appendix G: Crosswalk From Healthy People 2000 Objectives to Healthy People 2010 Objectives (continued)

12.7					
12.8		17-4 ^a	15.1	1.1, 2.1,	12-1 ^a
12.8		17-5a ^a		3.1	
12.8		17-5b ^a	15.2	2.22, 3.18	12-7 ^a
			15.3		
13.1		21-1a ^a	15.4	2.26	12-10 ^a
13.1		21-1b	15.5		12-11 ^a
13.1		21-1c	15.6	2.27	12-13
13.2		21-2a,d ^a	15.7	2.25	12-14
13.2		21-2b-c	15.8		
13.3		21-3	15.9	2.5, 16.7	19-8
13.4		21-4 ^a	15.10	1.2, 2.3,	19-2, 19-3 ^a
13.5		21-5a ^a		17.12	
13.6		21-5b ^a	15.11	1.3, 17.13	22-6 ^a
13.7	3.17, 16.17	3-6 ^a	15.12	3.4, 16.6	
13.8		21-8a	15.13		12-12 ^a
13.8		21-8b ^a	15.14		12-15 ^a
13.9		21-9	15.15		
13.10			15.16		7-5b
13.11	2.12		15.17		
13.12					
13.13			16.1	2.2	3-1 ^a
13.14		21-10 ^a	16.2	3.2	3-2 ^a
13.15		21-15 ^a	16.3		3-3 ^a
13.16	9.9	15-31	16.4		3-4 ^a
13.17	3.9	27-2c ^a	16.5	2.23	3-5 ^a
			16.6	3.4, 15.12	
14.1		16-1c	16.7	2.5, 15.9	19-8
14.1d		16-1d	16.8	2.6	19-5
14.1g		16-1e	16.8	2.6	19-6
14.2		16-1a	16.8	2.6	19-7
14.3		16-4	16.9		3-9b ^a
14.4		16-18 ^a	16.10		3-10a-h ^a
14.5		16-10a	16.11		3-13 ^a
14.5		16-10b	16.12		3-11a ^a
14.6		16-12 ^a	16.12		3-11b ^a
14.7		16-5a ^a	16.13		3-12a ^a
14.8a		16-9a ^a	16.13		3-12b ^a
14.8b		16-9b ^a	16.14		
14.9	2.11	16-19a-b	16.15		
14.9	2.11	16-19c ^a	16.16		
14.10		16-17a-b, d ^a	16.17	3.17, 13.7	3-6 ^a
14.10		16-17c	17.1	8.1, 21.1	
14.11		16-6a	17.2		
14.12	5.10	1-3f ^a	17.3	1.13	
14.13			17.4		24-4 ^a
14.14		16-8 ^a	17.5		
14.15		16-20a-c ^a	17.6		
14.16			17.7		28-4 ^a
14.17		16-15 ^a	17.8	11.2	

Appendix G Crosswalk From Healthy People 2000 Objectives to Healthy People 2010 Objectives (continued)

17.9		5-5 ^a	19.3		25-3
17.10		4-7 ^a	19.4		25-9
17.10		5-10 ^a	19.5		25-4 ^a
17.10		28-5	19.5		25-5 ^a
17.11	2.24	5-2 ^a	19.6		25-6 ^a
17.11	2.24	5-3 ^a	19.7	20.3b-c	14-3e-f
17.12	1.2, 2.3, 15.10	19-2, 19-3 ^a	19.8		
			19.9	5.4, 18.3	9-8a ^a
17.13	1.3, 15.11	22-6	19.9	5.4, 18.3	9-8b ^a
17.14		5-1 ^a	19.9	5.4, 18.3	9-9a ^a
17.14		24-6 ^a	19.9	5.4, 18.3	9-9b ^a
17.15			19.10	18.4	13-6
17.16			19.10a	18.4a	9-10e ^a
17.17			19.10b	18.4b	9-10f ^a
17.18		1-3h ^a	19.11	5.11, 18.13	
17.19			19.12	18.10	7-2g ^a
17.20		16-23 ^a	19.13		25-18 ^a
17.21		14-17 ^a	19.14	18.9	1-3g ^a
17.22	22.4		19.15		25-15 ^a
17.23		5-13 ^a	19.15		25-19 ^a
			19.16	5.5, 18.15	25-11 ^a
18.1			19.17	18.11	7-3 ^a
18.2		13-1			
18.2		13-4 ^a	20.1		14-1a, e-f, h-i
18.2		13-5 ^a			
18.2a		13-2	20.1		14-1b-d, g, j-k ^a
18.2b		13-3			
18.3	5.4, 19.9	9-8a ^a	20.2		
18.3	5.4, 19.9	9-8b ^a	20.3	10.5	14-3a-c ^a
18.3	5.4, 19.9	9-9a ^a	20.3	10.5	14-6 ^a
18.3	5.4, 19.9	9-9b ^a	20.3	10.5	14-9
18.4	19.10	13-6 ^a	20.3a		14-3d
18.4	19.10	25-11 ^a	20.3b	19.7	14-3e
18.4a	19.10a	9-10e ^a	20.3c	19.7	14-3f
18.4b	19.10b	9-10f ^a	20.3e	10.5	14-3g
18.5			20.3f		14-2
18.6			20.4		14-11
18.7			20.5		14-20a-e ^a
18.8		13-7 ^a	20.5		14-21 ^a
18.9	19.14	1-3g	20.6		14-15 ^a
18.10	19.12	7-2g ^a	20.7		14-4 ^a
18.11	19.17	7-3 ^a	20.7		14-7 ^a
18.12			20.8		
18.13	5.11, 19.11	25-18 ^a	20.9		14-18 ^a
18.14			20.10		14-5a-d ^a
18.15	5.5, 19.16	25-11 ^a	20.11		14-22a ^a
18.16			20.11		14-22b-e
18.17			20.11		14-23a-c, f-h
19.1		25-2	20.11		14-24 ^a
19.2		25-1a-c ^a	20.11		14-27a-d ^a

Appendix G: Crosswalk From Healthy People 2000 Objectives to Healthy People 2010 Objectives (continued)

20.11		14-28b
20.11	10.9	14-28c
20.11		14-29a-f ^a
20.12		
20.13		
20.14		
20.15		
20.16		
20.17		
20.18		14-13 ^a
20.19		
21.1	8.1, 17.1	
21.2	20.11	3-10
21.3		1-4a ^a
21.3		1-4b ^a
21.3		1-4c
21.4		1-1 ^a
21.4		1-2 ^a
21.5		
21.6		
21.7		
21.8		1-8a-d
21.8		1-8i-t ^a
21.8a		1-8e-h ^a
22.1		
22.2		
22.3		
22.4	17.22	
22.5		
22.6		
22.7		23-7 ^a

^a Healthy People 2010 objective is modified from the comparable Healthy People 2000 objective; see Part B: Operational Definitions for a description of changes.



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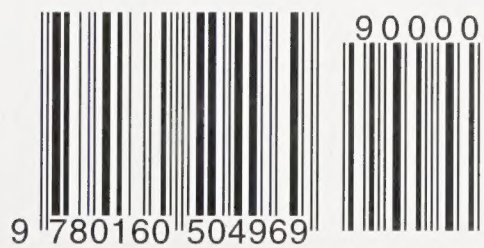
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